Jane A. Hayward, *Director*

Rhode Island Medicaid Program

Donald L. Carcieri, *Governor*

Annual Report
Fiscal Year 2002

building health care programs to meet community needs

Message from the Director

Access to appropriate, effective health care is a priority in Rhode Island. Rhode Island Medicaid cares for some of the state's most vulnerable populations and is an integral part of the state's overall health care system, serving 16 percent of Rhode Islanders.

The Department of Human Services produces the Medicaid Annual Report to provide the legislature, the administration and the public with information that will help these groups make informed decisions about Medicaid services and programming. The three sections of this year's report cover Medicaid's: (1) structure, financing and eligibility rules; (2) programs, populations, expenditures and evaluation efforts in the Center for Adult Health; and (3) programs, populations, expenditures and evaluation efforts in the Center for Child and Family Health. The report covers all Rhode Island Medicaid expenditures, including those made through other state departments and local school districts.

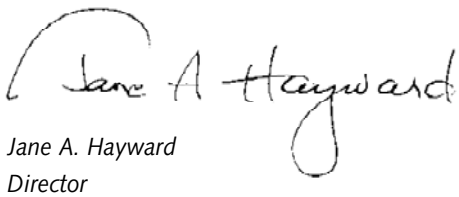
In fiscal year 2002, Medicaid spent $1.45 billion in state and federal funds to provide health care services to an average of 170,440 people each month. Medicaid provides access to health care for a range of populations, including: the elderly; persons with disabilities; children; and families. Adults with disabilities and the elderly account for 25 percent of the Medicaid population and 67 percent of total expenditures. Children and families, including children with special health care needs, make up 75 percent of the population and 33 percent of total expenditures.

Over 23,000 adults with disabilities were enrolled in Medicaid in fiscal year 2002, up six percent from 2001. The elderly population was stable at close to 18,600. Total expenditures increased for the adult population with disabilities under age 65 to $461 million, an average of $1,611 per client per month. Over $384 million was spent on services for the aged, with an average monthly per client cost of $1,659.

Efforts to stabilize the successful and expanding RIte Care program were realized in fiscal year 2002. Close to 117,500 children and families were enrolled in RIte Care, Medicaid's managed care program. Total expenditures for children and families were $262 million in fiscal year 2002. The average monthly per client expenditure was $184. RIte Share, the state's premium assistance program, grew to 2,000 members by the end of the fiscal year. Cost sharing for RIte Care and RIte Share enrollees was also implemented in fiscal year 2002.

Each month an average of 11,296 children with special health care needs were Medicaid eligible in fiscal year 2002. Total Medicaid spending on this population rose to $154 million, with an average monthly expenditure of $1,139 per child.

Rhode Island Medicaid continues to work hard to improve the health and health care of the state's most vulnerable populations. The Department of Human Services and its partners are committed to increasing access and quality of care while containing costs, as we continue *Building Health Care Programs To Meet Community Needs.* ▼



Jane A. Hayward
Director

Table of Contents

Introduction

The Rhode Island Department of Human Services produces the Medicaid Annual Report as part of its role as the designated agency responsible for Medicaid. The Rhode Island Department of Human Services (DHS) is the Medicaid single state agency responsible to the federal government and the state for the effective, efficient administration and supervision of Rhode Island Medicaid and for assuring statewide accessibility to a comprehensive system of high-quality health care services for Medicaid recipients.

The Department began compiling an annual report on Medicaid in fiscal year 1999. The report was prepared in response to a request from state policymakers for additional information about Medicaid expenditures to assist in evaluating program outcomes and promote greater fiscal accountability.

Using information from fiscal year 2001 for comparison, the fiscal year 2002 annual report provides updates on changes in Medicaid populations and program expenditures. The report highlights the activities of the Center for Adult Health (which serves adults with disabilities and the elderly) and the Center for Child and Family Health (the Center serving children and families). The report outlines current program services and initiatives, summarizes health care expenditures and utilization rates and describes efforts at measuring access, quality and outcomes.

Rhode Island has seized every opportunity to use the greater flexibility the federal government has given the states over the past ten years, expanding access to and improving the quality of Medicaid health care services and coverage. The state has made particular efforts to extend coverage to new population groups in order to improve health care outcomes and decrease the rate of uninsurance in the state. In 2000, Rhode Island's rate of uninsurance was 6.2 percent, the lowest in the nation. In addition, Rhode Island has used its waiver authority to provide specialized services to individuals who can benefit from them. These efforts have improved the lives of many adults with disabilities and elderly individuals who now have the option to obtain care in the community rather than in institutions. This flexibility has allowed Rhode Island Medicaid to implement its **Value-Based Purchasing Principle.**

When Medicaid began in the mid-1960s, the program was modeled on the indemnity health insurance plans that dominated the private market at that time. Under this "fee-for-service" model, Medicaid became a payer of medical claims incurred by its beneficiaries. A Medicaid recipient first identified a provider who would accept Medicaid's "fee-for-services performed" and then went to the provider for care. The provider submitted a bill to Medicaid, which Medicaid paid. While some argue that a passive role is the natural order for a government-run program, others contend that this approach ignores the state's considerable potential to leverage the

program's spending volume. This leverage enables Medicaid to conduct value-based purchasing in order to optimize the balance between the quantity, quality, and cost of services.

Throughout the 1990s, the Rhode Island Medicaid program, like others across the country, leveraged its purchasing power to transition from "payer" to "purchaser." Value-based purchasing involves contracting upfront with an organization that accepts payment for an agreed upon price for a specified service or range of services to Medicaid clients. The state, as the purchaser, sets standards (e.g., quality of care standards) for which the contracting organization is held accountable.

As a purchaser, the state can obtain services for all clients or subgroups of clients. The state can purchase one service, a specified range of services, or all Medicaid covered services. It can contract with one or many organizations/providers as needed. This process requires the state to develop and enforce contractual standards for health care quality and access. Value-based purchasing necessitates a good quality management system, including negotiated performance measures, member satisfaction surveys and focus groups, independent external reviews, data reporting and analysis, continuous quality improvement systems, and consequences for underachievers.

Over time, Medicaid has been shifting from being an after-the-fact payer of services to a value-based purchaser that can leverage its buying power to secure better and more cost-effective services and delivery systems for enrollees. This value-based purchasing principle enables Medicaid to promote better outcomes for the consumer and to gain more overall value for the public dollar.

Rhode Island Medicaid has also made changes to the range of populations it serves and the service delivery options it offers. Although Medicaid served a fairly limited population at its inception, state programs have been given incremental leeway to expand the individuals and families they cover. Rhode Island has chosen to provide Medicaid coverage to a number of optional groups. States can provide optional services, for which they receive federal matching funds.

The federal government requires the states to provide all Medicaid recipients with services that are comparable in scope, amount and duration. In the early 1980s, states were given the option to waive this and several other Medicaid requirements. Rhode Island established its first two waivers in 1983, and now administers six Home and Community Based Services (HCBS) waiver programs.

Rhode Island also administers a Section 1115(a) "research and demonstration" waiver. Section 1115(a) waivers allow states to explore new approaches to benefits, services, eligibility, program payments and service delivery. In 1994, Rhode Island used a Section 1115(a) waiver to implement RIte Care, the state's Medicaid managed care program for eligible children and families. ▼

ADMINISTRATION

The Department of Human Services is the designated single state agency with responsibility and accountability for the Medicaid program in Rhode Island. As the single state agency, DHS has statutory responsibility for:

1. **Oversight of the Medicaid state plan.** The DHS must administer or supervise the implementation of all aspects of the Medicaid state plan, including ensuring the correctness and accuracy of all financial and program reports as well as overseeing the scope and accessibility of services. The DHS cannot delegate its duties and responsibilities to other state or local agencies, although DHS is specifically authorized to enter into cooperative arrangements with other state and local agencies to maximize the utilization and coordination of medical assistance within Rhode Island.
2. **Statewide service availability, adequacy, quality.** The DHS is required to ensure that Medicaid services are available statewide.
3. **Statewide access to efficient eligibility determination.** The DHS is required to provide all Rhode Island residents with the opportunity to apply for medical assistance, assure that eligibility will be appropriately determined, and make sure that the state will furnish medical assistance with reasonable promptness, in a manner consistent with simplicity of administration and the best interests of the recipients.
4. **Choice of and equitable access to service providers.** The DHS is required to assure that individual recipients have a choice of providers both within the fee-for-service and managed care components of the program, while at the same time assuring that methods and payment rates are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available to the Medicaid population in all geographic areas of the state.
5. **Sufficient availability of basic services, including the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.** The DHS is required to assure that services are of sufficient amount, duration and scope for both mandatory and optional services; and that EPSDT screenings and necessary medical services are available to Medicaid eligible persons under age 21.

Each state must determine how to administer the program across multiple agencies that have overlapping responsibilities and authorities to serve a variety of eligible populations. As indicated in (1) above, DHS may enter into cooperative agreements with other state agencies in order to maximize the utilization and coordination of services for the Medicaid population; however, DHS cannot delegate its duties or responsibilities.

Exhibit 1
Rhode Island Medicaid Purchased and Directly Provided Services by Department
FY 2002

Population	Department of Human Services	Department of Children, Youth and Families	Department of Mental Health, Retardation and Hospitals	Department of Elderly Affairs	Department of Health	Local Education Agencies
Adults with Disabilities	Basic Medicaid services through direct pay to fee-for-service providers; Home and community based services		Behavioral health services to adults with severe and persistent mental illness; Substance abuse treatment; Certain home and community based services including group homes for adults with developmental disabilities and mental retardation; Slater Hospital	Certain home and community based services	Targeted case management for people with AIDS State laboratory	
Elderly Adults	Basic Medicaid services through direct pay to fee-for-service providers; Home and community based services		Behavioral health services to adults with severe and persistent mental illness; Substance abuse treatment; Certain home and community based services including group homes for adults with developmental disabilities and mental retardation; Slater Hospital	Certain home and community based services	State laboratory	
Children and Families in Managed Care	Basic Medicaid services through Health Plans plus fee-for-service wrap-around services; CEDARR in addition	Certain behavioral health services			State laboratory	Case management and school-related services; Individualized education plans (IEPs) for Medicaid-eligible special education students
Children with Special Health Care Needs	Basic Medicaid services through direct pay to fee-for-service providers; Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) family services	Residential placement; Certain behavioral health services			State laboratory	Case management and school-related services; Individualized education plans (IEPs) for Medicaid-eligible special education students
Children in Foster Care	Basic Medicaid services through direct pay to fee-for-service providers; CEDARR family services	Residential placement; Certain behavioral health services			State laboratory	Case management and school-related services; Individualized education plans (IEPs) for Medicaid-eligible special education students

Within these parameters and under Rhode Island state statutes, the Department of Human Services has shared stewardship for Rhode Island Medicaid with other agencies:

- Department of Mental Health, Retardation and Hospitals (MHRH)
- Department of Children, Youth and Families (DCYF)
- Department of Health (DOH)
- Department of Elderly Affairs (DEA)
- Local Education Agencies (LEAs)

The relationships that constitute this shared stewardship are complex. **Exhibit 1** illustrates the services that are either purchased or provided by each state agency on behalf of the five Medicaid population subgroups. **Exhibit 2** illustrates the total FY 2002 state and federal expenditures for the Medicaid program by department.

For a listing of programmatic partnerships and participating Departments and other stakeholders, please see the DHS web site at *www.dhs.state.ri.us.*

Within DHS, the Division of Health Care Quality, Financing and Purchasing (the Division) is responsible for administering the Rhode Island Medicaid program. The Division's program development, administration and staff are located in three centers:

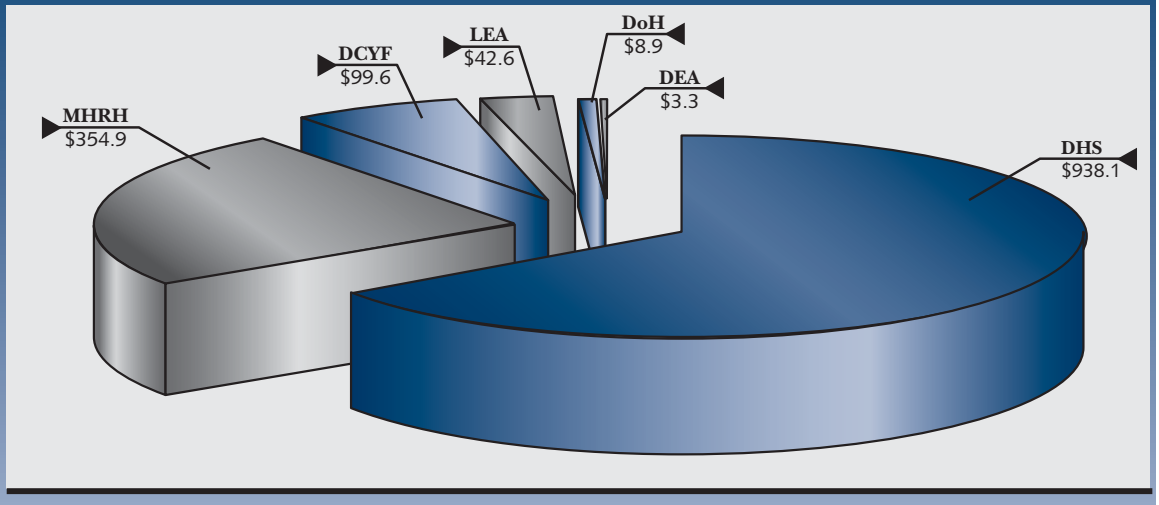
- Center for Adult Health
- Center for Child and Family Health
- Center for Finance and Administration

The Division has been implementing its consumer-focused value-based purchasing philosophy by adopting the following operating principles to develop and manage its programs:

- Assess consumer needs.
- Involve consumers in decisions that affect the services they receive.
- Involve providers in defining performance expectations that respond to consumer needs and assure the quality and accountability of service provision.

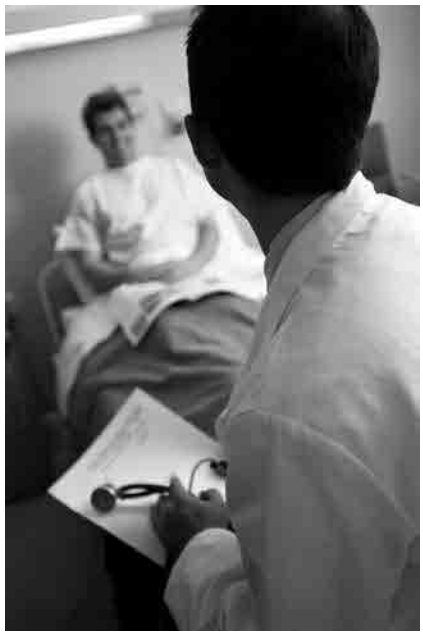
2

Exhibit 2
RI Medicaid Total Expenditures by Department in Millions - FY 2002



DHS - Department of Human Services
MHRH - Department of Mental Health, Retardation and Hospitals
DCYF - Department of Children, Youth and Families
LEA - Local Education Agencies
DoH - Department of Health
DEA - Department of Elderly Affairs

- Define benefits, design payment methodologies and create contract structures that support:
  - The improved health status of the consumer population;
  - The ability to obtain and maintain work opportunities for those with disabilities;
  - The cost-conscious expenditure of public funds; and
  - The use of data to track progress, inform decisions and continuously improve programs.



The Center for Adult Health (CAH) and the Center for Child and Family Health (CCFH) are responsible for program and policy development for the five Medicaid population subgroups. The activities of these two Centers are discussed in detail within Section II and Section III.

In addition to administering programs for adults with disabilities and elderly adults, CAH oversees the Medicaid Management Information System (MMIS) on behalf of the Division. The MMIS processes medical claims, makes capitation payments, enrolls providers, maintains eligibility information and generates financial and utilization reports. The Division is responsible for developing policies and procedures as well as monitoring the activities of its fiscal agent, Electronic Data Systems Corporation (EDS), as related to claims processing, provider relations and report generation.

As coordinator of the MMIS function, CAH has major responsibility for the implementation of and compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The intent of this federal legislation is to improve the availability and portability of health coverage through a variety of provisions. In addition, HIPAA, through its Administrative Simplification provision, requires the adoption of national standards for the electronic transfer of health care information including codes, identifiers, security and privacy. These standards will be binding on any individual or organization that stores, transmits and/or accepts health information.

In its capacity as a payer of over **$1 billion** in health care claims annually, Rhode Island Medicaid is in the process of transforming its systems and procedures to become compliant with HIPAA. In addition, Medicaid's service providers are looking to the state for assistance with their own compliance efforts. The CAH and its fiscal intermediary are working vigorously towards HIPAA compliance by the end of calendar year 2003, as required by law.

In addition to administering programs for children and families in managed care, children with special needs and children in foster care, CCFH oversees research and evaluation on behalf of the Division. The approach to research and evaluation originates from Medicaid's overarching goal, "to improve the health of the Medicaid population and, by so doing, improve the health of Rhode Island's population overall." Rhode Island Medicaid is working to ensure that programs measurably improve the health of the Medicaid population, and so need to be able to measure progress toward that goal. Research efforts assist programs by measuring and assessing progress.

Aided by a grant from the Robert Wood Johnson Foundation, Center for Health Care Strategies, Rhode Island has developed an innovative evaluation process - the Medicaid health indicator system. For each of the five population subgroups, The state is designing and implementing the system to (1) select specific health measures, (2) use existing data sets to create baseline measures and trend analyses and (3) design and conduct statewide surveys to determine population needs and program effectiveness. Significant progress has been made toward accomplishing these complex tasks. The publications already produced through this effort can be found on the DHS web site at *www.dhs.state.ri.us.*

The Center for Finance and Administration (CFA) encompasses all the core administrative functions of the Medicaid program: budgeting; financial expenditure analysis; hospital-related service monitoring and payment; program integrity; and recoveries from third parties for claims liability.

The CFA administers the Prospective Hospital Reimbursement Program on behalf of DHS. This program has its origins in state law. In 1971, amendments were added to the enabling legislation for nonprofit hospital service corporations. These amendments mandated that hospital budget negotiations were necessary for the purpose of determining payment rates for hospitals.

The current participants in the program are the state of Rhode Island* the twelve voluntary hospitals in the state, represented by the Hospital Association of Rhode Island (HARI), and Blue Cross of Rhode Island. The major components of the program are: a negotiated statewide maximum ceiling on reimbursable expenses (MAXICAP); negotiated individual hospital operating budgets; and establishment of third-party payment rates for inpatient and outpatient services.▼

* DHS has been designated by the RI Department of Administration to represent the state.

What is Medicaid?

Medicaid is a federally sponsored health care program for individuals and families with limited incomes and resources. The program was established by the federal government in 1965 as Title XIX of the U.S. Social Security Act.

In the years since the program was created, Medicaid has become both the primary payer and purchaser of health care for many individuals and families in need. Today, Medicaid is the chief source of funding for: long-term care for individuals with limited means; health care services for low-income adults with disabilities; and health care coverage for low-income families and their children and pregnant women and infants.

The federal government establishes core requirements concerning Medicaid funding, eligibility standards, and the quality and scope of medical services. Medicaid is an entitlement program; anyone who meets specified eligibility criteria may receive Medicaid services. Within this structure, states have flexibility to determine certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits and service delivery.

Title XIX requires that each state maintain a Medicaid State Plan that identifies the populations served, the criteria for determining eligibility, the scope of services provided, and the method of service delivery. The Medicaid State Plan is submitted for approval to the U.S. Centers for Medicare and Medicaid Services (CMS), the federal agency with oversight responsibility for state Medicaid programs. The Medicaid State Plan is an evolving rather than fixed document. A state must continually amend and/or revise its state plan to reflect the changes made in Medicaid program priorities and requirements.

Federal law also requires each state to centralize administrative, legal and financial responsibility for its Medicaid program in a "single state agency." The unit of government designated as such maintains the Medicaid State Plan, purchases the health care services and coverage authorized therein, and coordinates their delivery statewide. In Rhode Island, the single state agency is the Department of Human Services.

Exhibit 3
Rhode Island Medicaid Eligibility Pathways and Delivery System Options
(as of June 30, 2002)

Medicaid Population Subgroup	Eligibility Pathways	Delivery System Options
Children and families in managed care **(Children under 19 and their parents)**	• FIP/TANF • Section 1115 Waiver eligible • SCHIP • Certain poverty level children who are not eligible for TANF • 1931(e) Expansion parents	• Enrollment in a RIte Care Health Plan or RIte Share Premium Assistance Program • Limited FFS to fill in gaps in coverage • CEDARR
Children with special health care needs (as an eligibility factor) **(Under age 21)**	• Children who are – Blind and disabled SSI recipients – Katie Beckett eligible (eligible up to 18th birthday)	• Traditional Fee-for-Service (FFS) • CEDARR
Children in foster care (without special health care needs) **(Under age 21)**	• Children in – Foster care – Substitute care – Subsidized adoption	• Traditional FFS • RIte Care • CEDARR
Adults with disabilities* **(Age 21-64)**	• Blind and disabled SSI recipients • Medically needy • Medicare recipients below certain income level • Long term care eligible	• Traditional FFS • Connect CARRE • Waiver programs – Mentally Retarded and Developmentally Disabled (MHRH) – Aged and Disabled – Physically Disabled (PARI) – Assisted Living (DEA)
Aged* **(Age 65 and over)**	• Aged, blind and disabled SSI recipients • Medically needy • Medicare recipients below the poverty level	• Traditional FFS • Assisted Living Waiver (DEA) • Elderly Waiver (DEA) • Aged and Disabled Waiver • Physically Disabled (PARI) • Mentally Retarded and • Developmentally Disabled Waiver (MHRH)

* effective July 1, 2001, as authorized by the state budget, DHS increased eligibility for services to aged and disabled individuals with incomes up to 100 percent of the federal poverty level.

The Balanced Budget Act of 1997 added a new section to the Social Security Act - Title XXI. Title XXI established the State Children's Health Insurance Program (SCHIP), a federal/state program designed to provide health insurance coverage to previously uninsured children. Each state designed its own program within established federal guidelines. Rhode Island built on its previous expansion of child and family coverage by using SCHIP funding to expand its existing Medicaid program to cover more children.

Exhibit 3 displays the eligibility pathways and the service delivery system options available to each subgroup. The population has been divided into these four categories based on similarities of service need and complexity, as related to age, family structure and disability. ▼

WHO IS ELIGIBLE?

All state Medicaid programs must cover the following people:

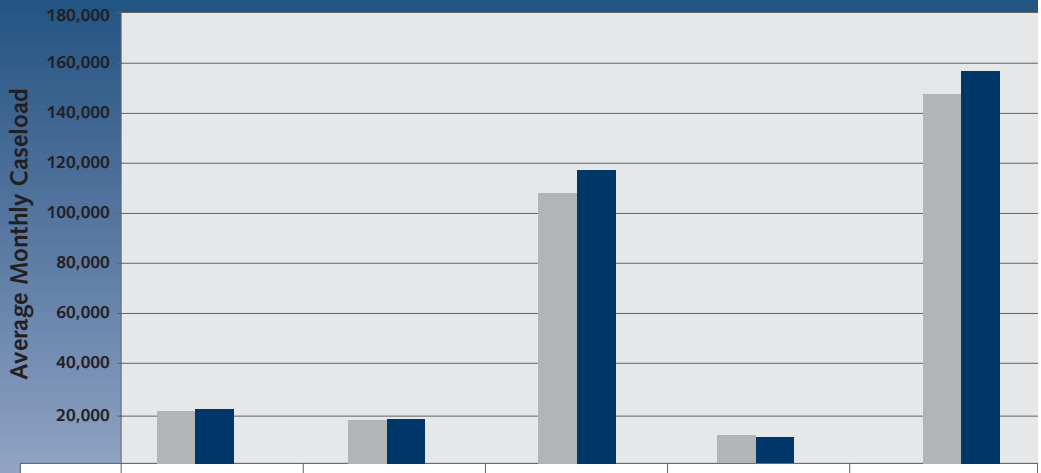
1. Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI)[1];
2. Low income Medicare beneficiaries.
3. Individuals who would qualify for Aid to Families with Dependent Children Program (AFDC) today under the state's 1996 AFDC eligibility requirements[2];
4. Children under age six and pregnant women with family income at or below 133 percent of federal poverty guidelines;
5. Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level;
6. Infants born to Medicaid-enrolled pregnant women;
7. Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program;

In addition, Rhode Island Medicaid has chosen to cover these optional groups:

1. Low-income elderly adults or adults with disabilities;
2. Individuals eligible for Home and Community Based Services waiver programs.
3. Children and pregnant women up to 250 percent and parents up to 185 percent of the federal poverty level, including children funded through the State Children's Health Insurance Program;
4. Individuals determined to be "medically needy" due to low income and resources or to large medical expenses;
5. Children under 18 with a disabling condition severe enough to require institutional care, but who live at home (the "Katie Beckett" provision);

1. SSI is a federal income assistance program for disabled, blind or aged individuals that is independent of individuals' employment status. SSDI is an insurance program for those who have worked a specified amount of time and have lost their source of income due to a physical or mental impairment.
2. Federal policymakers severed the tie between medical and cash assistance when the AFDC program was replaced in 1996. The AFDC standard was retained in Title XIX to prevent the states from using the more restrictive eligibility requirements and time limits of AFDC's successor – Temporary Assistance for Needy Families or TANF – when providing Medicaid coverage to needy children and families.

Exhibit 4
Rhode Island Medicaid Average Monthly Caseload by Population Subgroup - FY 2001 and FY 2002



Subgroup	Adults with Disabilities	Elderly	Children & Families in Managed Care	Children with Special Health Care Needs	TOTAL
FY 2001	21,707	18,429	106,953	12,475	**159,564**
FY 2002	23,116	18,568	117,460	11,296	**170,440**

Within DHS, the Division of Health Care Quality, Financing and Purchasing administers Rhode Island Medicaid. The program manages services for five population subgroups across two Centers:

The Center for Adult Health manages:

- Adults with disabilities; and
- Elderly adults

The Center for Child and Family Health manages:

- Children and families in managed care
- Children with special health care needs, including:
  - Children eligible due to SSI
  - Children eligible due to the Katie Beckett provision
  - Children in Subsidized Adoptions
  - Children in Substitute Care

Exhibit 4 displays the average monthly caseload[3] of Medicaid recipients by subgroup for fiscal year 2002. The total of 170,440 recipients broke down as follows:

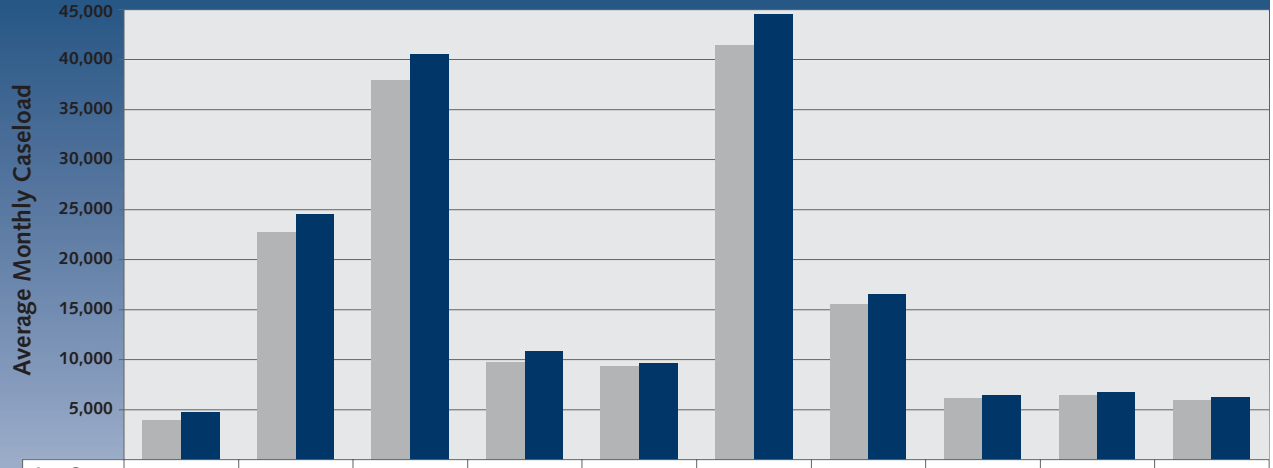
- 23,116 adults with disabilities
- 18,568 elderly adults
- 117,460 children and families in managed care
- 12,475 children with special health care needs

Exhibit 5 displays the FY 2002 Medicaid population by age group.

Exhibit 6 displays the Medicaid population as a percent of the Rhode Island populations of children and adults. Overall, Medicaid recipients made up 16 percent of the state population. Medicaid covered an estimated 33 percent of all Rhode Island children under age 18 years and 11 percent of persons 18 years and older during 2002.▼

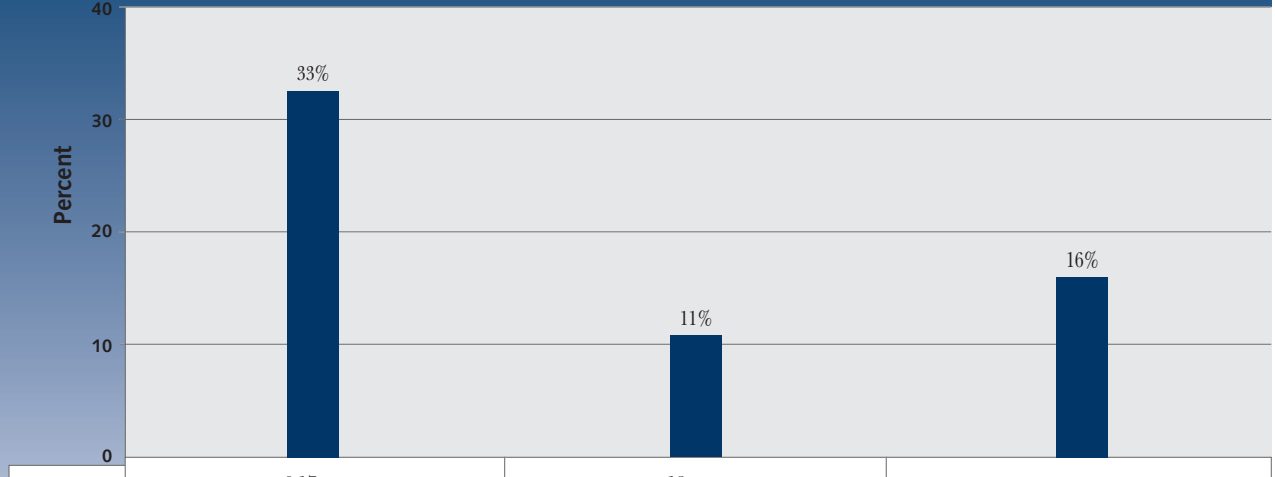
3. The average monthly caseload of Medicaid recipients represents the number of individuals enrolled in a given month regardless of the length of time they were eligible (from 1 to 31 days). The average monthly caseload for the year is calculated by averaging the monthly caseload for 12 months. The unduplicated count of Medicaid recipients represents the number of unique individuals enrolled during the year regardless of the length of time they were eligible (from 1 to 365 days). The unduplicated count is higher than average monthly caseload. Average monthly caseload is used in most budgeting and financial calculations and in the caseload estimating conferences.

Exhibit 5
Rhode Island Medicaid Average Monthly Caseload by Age Group - FY 2001 and FY 2002



Age Group	0-1 yrs	1-5yrs	6-14 yrs	15-17 yrs	18-21 yrs	22-44 yrs	45-64 yrs	65-74 yrs	75-84 yrs	85 yrs +
FY 2001	4,471	22,807	37,896	9,752	9,333	41,373	15,499	6,158	6,411	5,939
FY 2002	4,973	24,610	40,474	10,542	9,686	44,489	16,427	6,473	6,723	6,045

Exhibit 6
Rhode Island Medicaid Average Monthly Caseload as a Percent of Rhode Island Population FY 2002



Age Group	0-17 yrs	18 yrs +	Total

Source: US Census 2000

What services are covered?

Exhibit 7 lists the services covered by Rhode Island Medicaid. All recipients are eligible to receive "Basic Medicaid Services" unless otherwise specified. Please note that:

- To be eligible as medically needy, a recipient must have income and resources below specified limits, or have large medical expenses;
- To be eligible for waiver services, recipients must meet specific criteria. (For information on waiver programs, please see see the DHS web site at www.dhs.state.ri.us)
- To be eligible to participate in federal Medicare buy-in, a recipient must meet Medicare requirements and have income and resources below specified limits.

Exhibit 7
Rhode Island Medicaid State Plan Services
FY 2002

Basic Medicaid Services — Mandatory State Plan Services plus Optional State Plan Services offered in RI, i.e.:

Mandatory State Plan Services

States are required to offer coverage to the categorically needy for these services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and x-ray services
- Nursing facility services for individuals 21 and older
- Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21
- Family Planning services
- Physicians' services
- Home health services for any individual entitled to nursing facility care
- Nurse-midwife services to the extent permitted by State law
- Services of certified nurse practitioners and certified family nurse practitioners to the extent they are authorized to practice under State law

Optional State Plan Services offered in RI

- Podiatrists' services
- Optometrists services
- Dental services
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Diagnostic services
- Preventive services
- Rehabilitative services
- Services in an IMD for individuals age 65 and over
- Inpatient psychiatric services for individuals under age 21
- NF services for individuals under age 21
- Personal care services
- Transportation services
- Case management services
- Hospice services
- TB services for certain TB infected individuals

Medically Needy State Plan Services — prenatal & delivery for pregnant women, ambulatory services for individuals under 18 and those entitled to institutional care, home health services for individuals entitled to nursing facility services, mandatory state plan services for over 65 & under 21 in an IMD or ICF/MR.

Waiver Services — Home or community based services not otherwise furnished under the State's Medicaid plan and have been approved under a waiver request to HCFA. These consist of any or all of the following: case management services, homemaker services, personal care services, adult day health services, habilitation services, respite services, minor assistive devices, minor modifications to the home, and other medical or social services as requested by the state and found to be cost-effective to prevent institutionalization.

Federal Medicare Buy-in — direct payment or annual stipend to pay Medicare deductibles, co- payments and coinsurance, only.

Employer Sponsored Health Insurance (ESI) Premium Assistance — If cost-effective, the state pays the employees share of ESI premium if Medicaid eligible has access to ESI.

Enrollee Co-premium — Under managed care programs for children and familes, enrollees must pay a sliding scale co-premium based on family income.

Exhibit 8
RI Medicaid State and Federal Matching Rates 1999 to 2003

	Medicaid Title XIX	
Federal FY	**State %**	**Federal %**
1999	45.95%	54.05%
2000	46.23%	53.77%
2001	46.21%	53.79%
2002	47.55%	52.45%
2003	44.60%	55.40%
	Schip Title XXI	
Federal FY	**State %**	**Federal %**
1999	32.17%	67.83%
2000	32.36%	67.64%
2001	32.35%	67.65%
2002	33.28%	66.72%
2003	31.22%	68.78%

For each dollar spent on Medicaid in Rhode Island, the state and federal governments contributed the above percentages.
Source: Center for Medicare and Medicaid Services

Exhibit 9
Rhode Island Medicaid Total Expenditures FY 2002

Line Items/ Departments	Expenditures	Percent
Hospital - Regular	$ 116,324,457	8.0%
Hospital - Disproportionate Share payments	$ 84,321,945	5.8%
Nursing Homes	$ 255,145,489	17.6%
Managed Care	$ 257,339,670	17.8%
Other	$ 183,427,926	12.7%
Restricted Receipt	$ 6,792	0.0%
Administration-DHS	$ 41,528,262	2.9%
Total DHS	$ 939,094,541	64.8%
Total MHRH	$ 354,946,285	24.5%
Total DCYF	$ 99,614,748	6.9%
Total LEA	$ 42,604,804	2.9%
Total DOH	$ 8,891,683	0.6%
Total DEA	$ 3,299,901	0.2%
Total Other	$ 886,012	0.1%
TOTAL ALL DEPARTMENTS	**$1,448,337,974**	**100.0%**

DHS: RI Department of Human Services
MHRH: RI Department of Mental Health, Retardation and Hospitals
DCYF: RI Department of Children, Youth and Families
LEA: Local Education Authorities
DOH: RI Department of Health
DEA: RI Department of Elderly Affairs

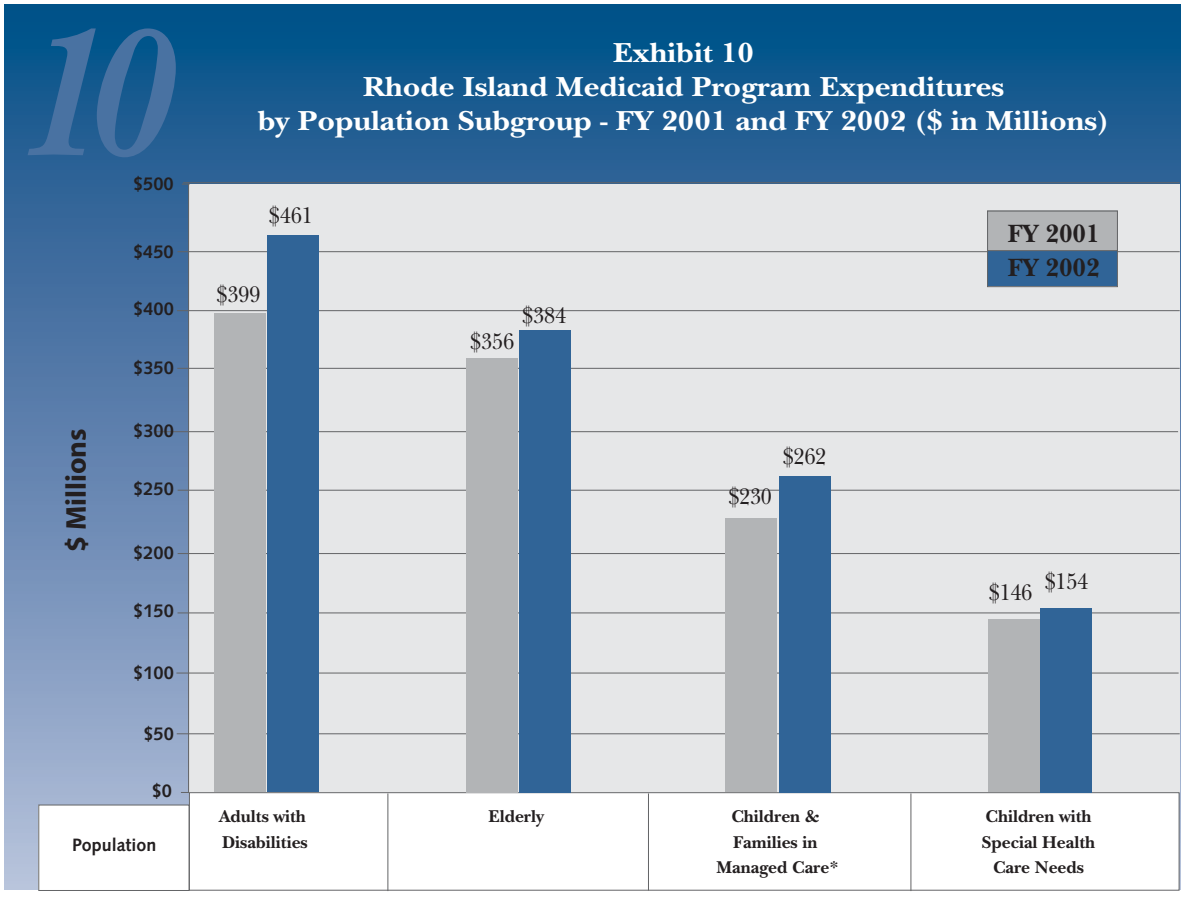
How is Medicaid Financed?

The federal and state governments each contribute funds to Medicaid. For administrative costs, the federal government contributes 50 percent of total expenditures, with enhanced federal funding provided for some administrative activities, such as fiscal agent operations. For medical services, the federal government contributes at least 50 percent of total expenditures. The federal matching assistance percentage (FMAP) varies across states and is adjusted annually. States with lower per capita incomes receive a higher federal match. The FMAP ranges from the minimum of 50 percent in California, Colorado, Connecticut, Delaware, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York and Washington, to almost 77 percent in Mississippi. The Medicaid FMAP for Rhode Island was 52.45 percent in federal fiscal year 2002.

Exhibit 8 displays Rhode Island's FMAP rate from 1999 through 2003 for Title XIX (Medicaid) and Title XXI (SCHIP)[4] expenditures. Medicaid enrollment is not limited based on a pre-set expenditure cap. By federal law, eligible individuals cannot be denied enrollment or covered services based on insufficient government funds.

Exhibit 9 shows total combined federal and state expenditures for Rhode Island Medicaid in FY 2002. Total expenditures for benefits and administration were $1.45 billion. Medicaid expenditures constitute a sizable proportion of the total state budget. In fiscal year 2002, Medicaid accounted for 22.6 percent of the state budget. ▼

4. Through SCHIP, the federal government provides states with an "enhanced" FMAP rate to encourage enrollment of children in the program.



* excludes residential services for children in foster care enrolled in RIte Care.

How are Medicaid dollars used?

Exhibit 10 displays Medicaid expenditures by population group. Total program expenditures grew 12 percent between fiscal years 2001 and 2002. The largest absolute and percentage increase occurred in the adults with disabilities subgroup.

Exhibit 11 compares the caseload distribution for each subgroup with the associated distribution of expenditures. While children and families in managed care represent 69 percent of the total caseload, they account for only 21 percent of program expenditures. Conversely, adults with disabilities and the aged combined represent 25 percent of the total caseload but account for 67 percent of all expenditures.

In addition, **Exhibit 12** displays medical expenditures by category of service provider, ranked by expenditure volume:

- $359 million for institutional service providers (nursing homes and Eleanor Slater Hospital)
- $328 million for home and community based services
- $164 million for acute-care hospitals
- $155 million for pharmaceuticals
- $139 million for physicians and other services
- $116 million for providers of behavioral health services

Exhibit 11
Rhode Island Medicaid Percent Program Expenditures vs Percent Caseload by Population Subgroup - FY 2002

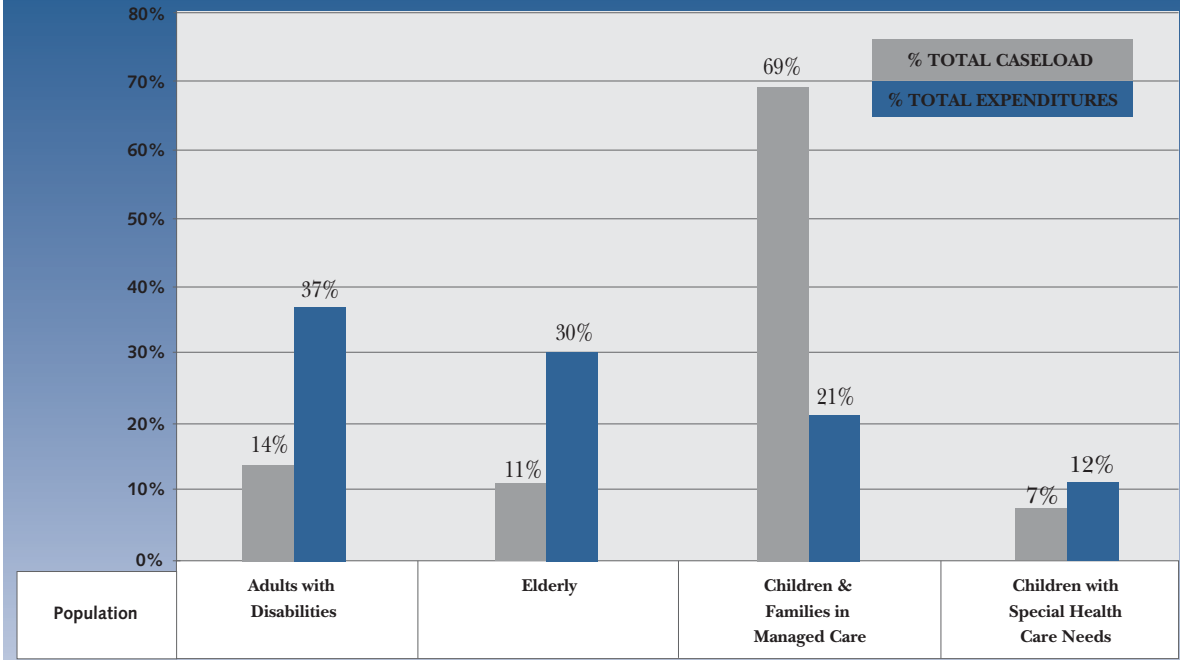
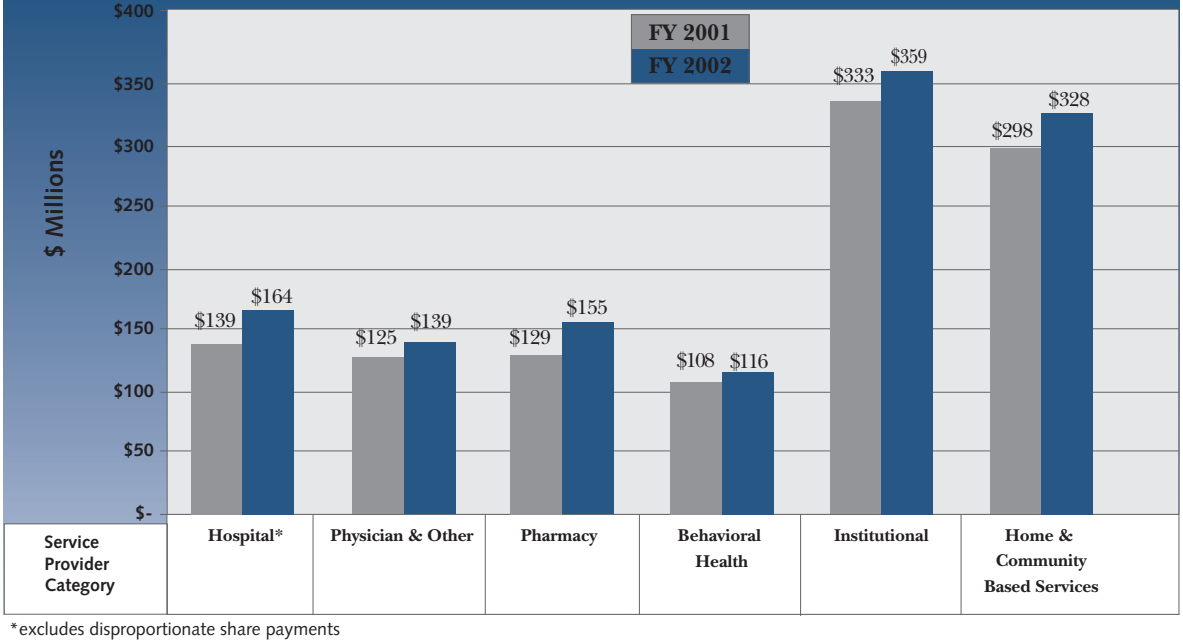
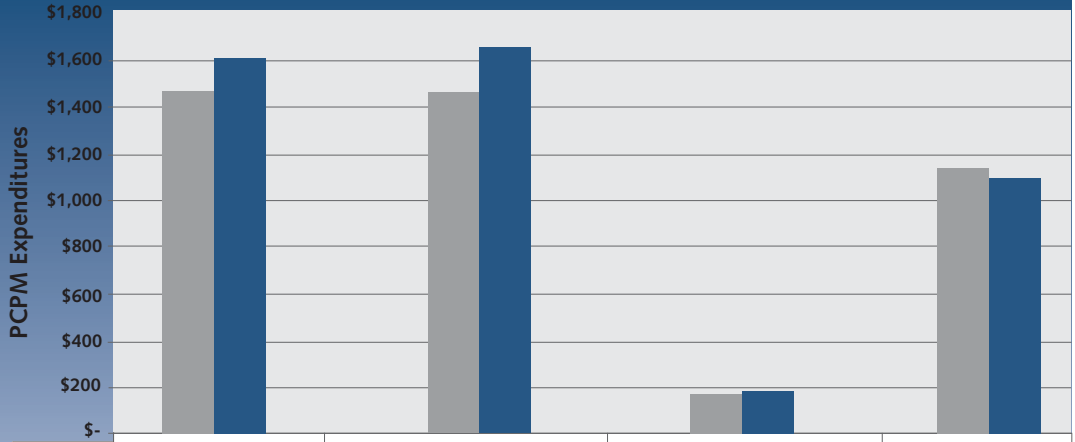


Exhibit 12
Rhode Island Medicaid Program Expenditures by Service Provider Category FY 2001 and FY 2002 ($ in Millions)



*excludes disproportionate share payments

Exhibit 13
Rhode Island Medicaid Per Capita Per Month (PCPM) Program Expenditures – FY 2001 and FY 2002



Population	Adults with Disabilities	Elderly	Children & Families in Managed Care	Children with Special Health Care Needs
2001	$1,477	$1,471	$167	$1,153
2002	$1,611	$1,659	$184	$1,139

Per Capita Per Month Expenditures

Average per capita per month (PCPM) costs are shown in **Exhibit 13.** The per capita spending on children and families in managed care is significantly lower than the PCPM for other populations. In 2002, the PCPM for the elderly increased the most over the previous year. The PCPM for children with special health care needs decreased one percent from FY 2001. ▼

Programs & Initiatives

Waiver Programs

Most of the adults with disabilities and elderly adults enrolled in Medicaid receive services through the traditional Medicaid program. In addition, some individuals participate in one of Rhode Island's six home and community based services (HCBS) waiver programs. Waiver program participants receive home and community based services along with the full range of traditional Medicaid services.

The Department of Human Services (DHS) administers the Aged and Disabled waiver program. Enrolled individuals are eligible for case management, personal care, environmental modifications, special medical equipment, Meals-on-Wheels, senior companion and emergency response services. The waiver was initially approved in 1983 and is approved through 2003. In fiscal year 2002, 1,782 individuals received services through the Aged and Disabled waiver program.

The **Physically Disabled** waiver is administered through a partnership between the Department of Human Services (DHS) and the People Actively Reaching Independence (PARI) Independent Living Center. Independent living agencies provide case management and personal care services for individuals with quadriparesis or functional hemiparesis. Participants may receive case management, a personal care attendant, consumer preparation, environmental modifications, special medical equipment, homemaker services and emergency response services. 84 individuals received services through this waiver in FY 2002. The waiver began in 1988 and is approved through 2004.

The **Assisted Living** waiver is a collaborative effort of DHS, Department of Elderly Affairs and Rhode Island Housing and Mortgage Finance Corporation, and provides services to some individuals residing in assisted living facilities. The waiver funds case management, assisted living and special medical equipment for eligible individuals residing in assisted living facilities. The waiver began in 1999 and in 2002 was re-approved through 2007. As of December 2002, 248 people were eligible to receive services through this waiver.

The DHS and the Department of Mental Health, Retardation and Hospitals (MHRH) administer the **Mentally Retarded, Developmentally Disabled** waiver. Services funded under this waiver include case management, specialized homemaker, adult foster care, homemaker, respite, environmental modifications, special medical equipment, residential day habilitation and supported employment. In FY 2002, 2,426 persons received waiver services. The waiver program was initiated in 1983 and is approved through 2006.

The DHS and Department of Elderly Affairs (DEA) administer a waiver for **Community Based Elderly** Medicaid recipients. Eligible individuals must be over age 65, and can receive case management, homemaker, personal care, Meals-on-Wheels, senior companion, environmental modifications and special medical equipment. In FY 2002, 503 Rhode Islanders received services under this waiver. The waiver began in 1988 and is approved through 2006.

A new home and community based program called the **Habilitation Waiver** started in May 2002. This program is for people who require daily habilitative and/or skilled nursing services to a degree that can not be provided adequately at a nursing facility level of care. The services covered under this waiver include:

- Case management (provided by PARI Independent Living Center)
- Residential Habilitation (licensed by MHRH)
- Day Habilitation (licensed by MHRH)
- Supported Employment (licensed by MHRH)
- Private Duty Nursing, and
- Rehabilitation services provided in licensed free-standing rehabilitation settings

One person was enrolled in FY 2002. This waiver is in its first approval period, which runs through 2005.

Long Term Care Initiative

State policy makers have long expressed concern about the escalating cost of and increasing demand for high-quality long-term care services for elderly individuals and/or those with chronic disabilities. Recently, financial pressures, workforce shortages and the state's aging population, among other issues, have heightened concern about the capacity and fiscal viability of the state's long term care system. In response to these and other concerns, the Governor and General Assembly established the Joint Long Term Care Administration/Legislative Work Group to search for workable solutions. The Committee was charged with identifying the state's options for strengthening the system and making sustainable reforms and establishing a strategy for implementing such efforts. The Committee outlined the essential elements of and steps in the reform process, and developed a path for shaping legislatively sustainable reform.

In fiscal year 2002, the state legislature passed a joint resolution to reform and finance long-term care services through a consumer-centered system of coordinated services and integrated care. It directs the state agencies to both shore up the long-term care system and develop infrastructure to support improvements.

Breast and Cervical Cancer Program

In FY 2002, the DHS, DOH and representatives of breast cancer organizations designed and implemented a program to allow women with breast or cervical cancer or pre-cancerous symptoms to gain Medicaid eligibility. There are no income requirements for this program, but to be eligible a woman must be screened by the DOH-administered Women's Cancer Screening Program. The screening program is funded by the Federal Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program. The screening program provides no-cost pelvic exams, Pap tests, clinical breast exams, and mammograms to women who meet the following eligibility characteristics:

- Live in Rhode Island;
- Have no insurance coverage for services provided by the program;
- Have family income up to 250 percent of the federal poverty level; and
- Be under age 65.

Any woman screened by a provider who participates in the program and found to have cancer or pre-cancerous symptoms can enroll in Medicaid for the duration of her treatment. Although eligibility for coverage is based on the woman's need for cancer-related treatment, enrolled women are eligible to receive the full scope of services provided to individuals found eligible for

Medicaid as categorically needy, whether or not the services are related to the treatment of cancer or pre-cancer.

Participants

Coverage was provided to 187 women during the first eight months of the program's operation. Of the total, 60 became eligible due to a cancer diagnosis; 49 of them had breast cancer and 11 had cervical cancer. The other 115 women were eligible due to a pre-cancerous condition (71 for pre-breast cancer, 44 for pre-cervical cancer).

A woman is eligible for coverage under this program until one of the following occurs: her course of treatment for breast or cervical cancer ends; she turns 65; she gains creditable coverage; she fails to complete a scheduled redetermination; or she is no longer a Rhode Island resident. Nineteen women have left the program when treatment for their cancer or pre-cancerous symptoms was completed.

Services and expenditures for enrolled women

Participating women received a range of services in multiple settings. In the first eight months of the program, the percent of expenditures by service setting setting were as follows:

- 44% outpatient facility
- 27% inpatient facility
- 12% physician
- 12% pharmacy
- 5% other

During the first eight months the program was in operation, Medicaid paid for over 2,100 radiology procedures for these women, as well as over 3,500 clinical laboratory procedures and more than 1,700 physician visits. Eighty-seven percent of lab procedures performed for these women occurred in hospital outpatient departments, and 58 percent of the office visits were provided in physician offices.

Women enrolled in the program may receive all needed services, both for treatment of their cancer and for other medical conditions. For women who participate, Medicaid enrollment improves their access to services that may have been unavailable or unaffordable without insurance. Eighteen percent of the participants accessed dental services, fifteen percent utilized behavioral health services, and seven percent obtained medication to reduce their cholesterol.

TBI Implementation Grant

In March 2002, the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) awarded a three-year, $600,000 Traumatic Brain Injury (TBI) Implementation Grant to the DHS Center for Adult Health. The successful completion of the Rhode Island Plan for TBI Services under the DHS 2000 HRSA TBI Planning Grant led to this proposal and subsequent award.

The TBI Implementation Project will strengthen the TBI service delivery infrastructure through development of the following components:

- A comprehensive resource center for TBI survivors, families, and treating professionals
- Training videotapes and curricula about specific needs of Brain Injury survivors for providers of Service Coordination, Vocational Services, Developmental Disability Services, Home Health Care, Behavioral Health and Substance Abuse Services
- Multi-language fact sheets and resource directories distributed statewide
- Annual conferences targeted to survivors, families and professionals, and
- Quarterly educational radio broadcasts

The Brain Injury Association of Rhode Island was awarded the contract to conduct grant activities in collaboration with the DHS Center for Adult Health.▼

PACE

In FY 2002, the National PACE Association awarded Rhode Island a grant to develop a Program of All-inclusive Care for the Elderly (PACE). PACE gives seniors access to a full range of preventive, primary, acute, and long term care services, focusing on enabling enrollees to live in the community. The Rhode Island PACE steering committee includes representatives from various state agencies, consumers, the legislature, the governor's office, the lieutenant governor's office, and providers. Workgroups were established to identify issues and recommendations regarding rate setting, eligibility, enrollment, regulations and quality oversight.

Systems Change Grants for Community Living

Real Choice Systems Change Grant

In fiscal year 2002, CMS informed the state that it was funding Real Choice grants directed at adult populations. (see Children with Special Health Care Needs for information on an additional grant.) Funded at $1.385 million over three years, the grant will: expand capacity to needed services; increase information to facilitate consumer choice; and improve the integration of health and social services. The grant will be used to develop a web-based benefits screener and resource directory, develop service-tracking software, host a conference on community based services, conduct a needs-assessment survey of long-term care consumers, analyze Medicare data to identify patterns of individuals likely to become dually Medicare/Medicaid eligible, provide behavioral health consultation to non-institutional residences, track and analyze residential and community-based systems of care, and improve the transition for youth with serious emotional disturbances who transition to the community.

Nursing Facility Transitions Grant

The second grant approved by CMS will expand an established program of intensive service coordination and community supports for institutionalized individuals in order to help them transition to a community-living arrangement. The program will: provide institutionalized persons with information on community service options; help interested persons transition to a community living arrangement with necessary supports; and enhance the capacity of the home and community based system to serve individuals with multiple or complex needs.

Chronic Care Programs

Connect CARRE

Connect CARRE is a care management and wellness program that provides comprehensive services to consumers with declining health and frequent illnesses. The program involves ongoing analysis of service utilization patterns for health indicator screenings and chronic care and disease management.

Participants in Connect CARRE are at risk for recurrent adverse medical events that lead to frequent hospitalizations and emergency room visits. Participants live in community settings but often lack social and community supports.

Connect CARRE links consumers to a medical home and a team of providers and care coordinators, including a Lead Physician and a Nurse Care Manager. The program helps consumers develop more consistent and supportive relationships with their health care providers, assists consumers and their families to manage chronic illness through educational programs, and identifies and coordinates services and care in the community in order to help consumers maintain wellness and reduce recurrent illness.

The program utilizes a care management model and includes disease management principles that support physician practice. Connect CARRE's consumer focused model provides enhanced benefits and utilizes health outcomes as program measures. Based on an initial consumer needs assessment, the clinical team (nurse care manager, assistant medical director, pharmacist and social worker) develops a care plan. Care management and services along the continuum are coordinated by the nurse care manager.

In addition to improving participant wellness, Connect CARRE strives to maintain or improve the individual's functional status,

increases his or her ability to manage their care, and decreases preventable hospitalizations and emergency department use. The program helps DHS identify gaps in the current delivery system and increase capacity to meet the needs of the target population.

Through Connect CARRE, in FY 2002 DHS conducted outreach to 500 patients of physicians who had closed their practices. The Department offered a list of resources throughout the state and maintained a hotline for individuals needing more assistance in finding a new provider. Callers were helped to find new physicians and receive follow up care.

Dual Eligibles Diabetes Project

The DHS participates in the Rhode Island Quality Partners (RIQP) effort to target dual eligible beneficiaries with diabetes. Medicaid-Medicare recipients living in the community can participate in the RIQP Diabetes Project. The goal is to improve lipid evaluations in diabetics. An intervention has been designed and implemented, and the program is currently collecting data to monitor the intervention's impact.

Department of Health Ocean State Immunization Coalition for Flu and Pneumonia Immunization in Community

The Ocean State Adult Immunization Coalition is a joint effort by DHS, DOH, Rhode Island Quality Partners, long-term care and home care agencies and the Visiting Nurses Association. The group is working to improve flu and pneumonia immunization rates for the over-65 and high-risk under 65 populations.

Long Term Care/Nursing Facility Flu and Pneumonia Immunization Project

This project provides education and technical assistance to help nursing facilities in their efforts to provide flu and pneumonia immunizations to all nursing facility residents and staff. The DOH monitors the project results to ensure that immunizations reach 100 percent.

Drug Utilization Review

The Drug Utilization Review (DUR) Board is DHS's effort to oversee pharmaceutical use in Medicaid, in order to ensure that medications are utilized appropriately and cost-effectively. The Board is made up of physicians, pharmacists, and other health care professionals working in Rhode Island. The Board meets quarterly

to review DUR criteria. In addition, DHS conducts prospective DUR through online edits and audits and in-pharmacy discussions with patients to ensure that duplicate or interacting medications are not prescribed. A contractor conducts retrospective utilization review for Medicaid-payable prescription drugs, tracks trends in prescriptions, and provides information to help physicians improve their prescribing practices.

Medical Transportation

Many elderly citizens and people with disabilities receiving Medical Assistance need assistance with transportation to access medical services. Individuals are encouraged to seek help from friends, neighbors and families members. In addition, many health centers, community agencies and volunteer groups provide rides. When none of these are available, the state can provide assistance.

The Rhode Island Public Transportation Authority (RIPTA) provides "no fare" and free ride programs to Medical Assistance enrollees who apply for a RIPTA Senior/Disabled Bus Pass. The RIDE Program provides door-to-door transportation to medical appointments to people over age 60 and individuals with disabilities. Appointments require prior approval and must be made two weeks in advance of the date the transportation is needed.

When an individual goes to the hospital and can not take the same transportation home, hospital staff help find appropriate transportation. Hospitals are authorized to bill for transportation. When none of these are available or appropriate, the medical transportation hotline will provide further assistance. ▼

ADULTS WITH DISABILITIES

Population Characteristics

Medicaid's average monthly caseload of adults with disabilities (age 21 to 64) was 23,116 in fiscal year 2002. This is a six percent increase from the previous year. By disability, disease or illness, adult Medicaid enrollees with disabilities fell into one of three population groups:

- Individuals with developmental disabilities and mental retardation;
- Individuals who are severely and persistently mentally ill; and
- Individuals who are physically disabled and/or chronically ill.

These three groups have different health care needs and are eligible for a range of services related to their diagnoses. Some individuals are eligible for services through Waiver programs, while others can receive coordinated care through the Connect CARRE program. For these and other Medicaid recipients, services are provided in the community, in a nursing home or other residential facility depending on the individual's need for care and services.

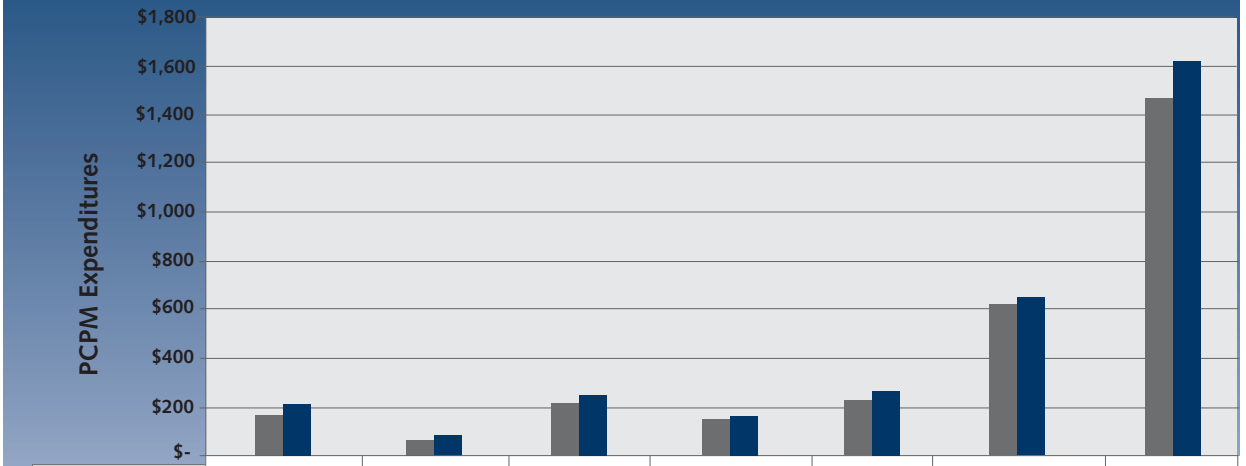
Services and Expenditures

In FY 2002, Medicaid spent $461 million on services for adults with disabilities, a 15 percent increase over the previous year. The average per client per month spending (PCPM) was $1,611. The following chart shows the average monthly per-client Medicaid spending in these categories in fiscal years 2001 and 2002:

The average monthly expenditures per client grew nine percent between fiscal year 2001 and 2002. Average monthly expenditures per client increased in every service provider category between 2001 and 2002. Home and community-based services remained by far the largest expenditure category, accounting for more than twice the spending of the next highest category, insti-

14

Exhibit 14
Adults with Disabilities
PCPM Program Expenditures by Service Provider
FY 2001 and FY 2002



Service Provider Category	Hospital	Physician & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM TOTAL
2001	$177	$76	$215	$161	$236	$611	$1,477
2002	$210	$82	$243	$167	$266	$644	$1,611

tution-based services. The three largest expenditure categories, accounting for over 70 percent of all expenditures, were as follows:

- $644 PCPM for home and community based services
- $266 PCPM for institutional services
- $243 PCPM for pharmacy

Elderly Adults

Population Characteristics

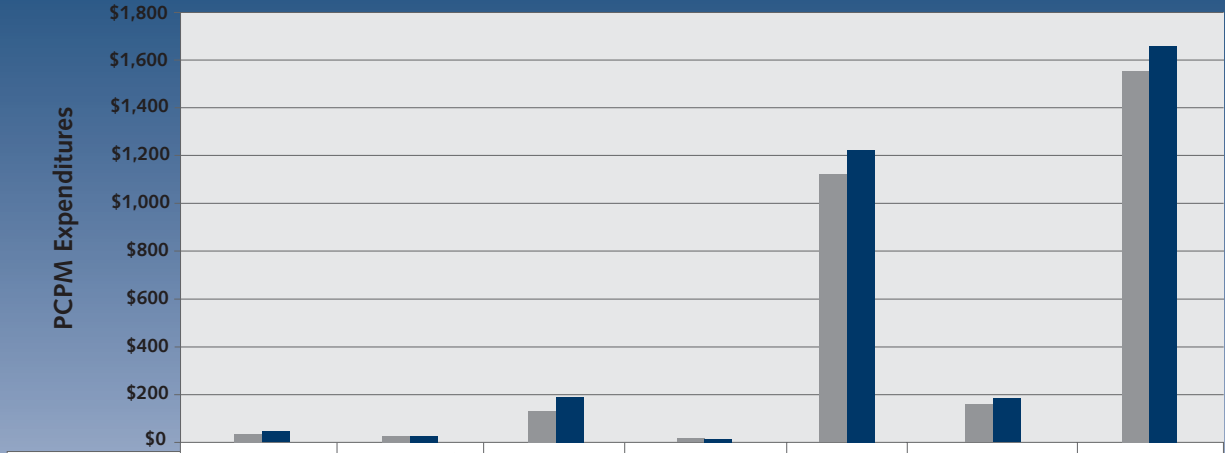
In fiscal year 2002, the average monthly caseload of recipients age 65 and over was 18,568. (The FY 2001 average was similar, at 18,429.) Aged enrollees had a range of physical and mental health problems and were served through several service types. Close to a quarter of elderly eligibles received services in nursing homes. Ninety-four percent of Medicaid-funded nursing home residents were over 65 in fiscal year 2002.

Services and Expenditures

In fiscal year 2002, Medicaid spent over $382 million on services for aged recipients, an increase of 13 percent over FY 2001. Fiscal year 2002 PCPM expenditures for elderly recipients totaled $1,659. Approximately three-quarters of expenditures, or $1,208 PCPM, for elderly recipients were for institutional services. Monthly per member costs for prescription drugs rose in fiscal year 2002, becoming the second largest category of monthly expenditures for the elderly population. ▼

15

Exhibit 15
Elderly Adults
PCPM Program Expenditures by Service Provider
FY 2001 and FY 2002



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM TOTAL
2001	$37	$19	$161	$12	$1,156	$168	**$1,553**
2002	$45	$20	$187	$12	$1,208	$186	**$1,659**

Tracking Access, Quality and Outcomes

The Research and Evaluation Project continued to investigate the health needs of Medicaid-eligible adults with disabilities. Over the past several years, evaluations have been performed to collect information on this population, through focus groups, a statewide survey and analysis of baseline and comparison years' utilization data. In Fiscal Year 2002, data from 2000 was added to health care utilization data for 1998 and 1999.

Using these research methods, the Research and Evaluation Project has identified several consistent themes. To begin with, many Medicaid enrollees have multiple health problems. Often individuals suffer from both mental and physical conditions. Adult Medicaid recipients who live with disabilities and chronic conditions have complex needs for a wide spectrum of services. The CAH evaluations provide evidence that many individuals have unmet needs for disease, treatment and care information, would benefit from stable connections with providers, and need assistance with their full range of medical, psychological and social services. The CAH is using evaluation findings to identify ongoing client needs, develop programs and improve existing efforts, in order to improve access to and quality of care for program participants. ▼

Programs & Initiatives

The Center for Child and Family Health (CCFH) administers the delivery of health services for the following Medicaid populations:

- Children under age 19 living in families with incomes up to 250 percent of FPL
- Pregnant women with incomes up to 250 percent of FPL
- Parents of RIte Care enrolled children, with family incomes up to 185 percent FPL
- Children with special health care needs, including those eligible for Medical Assistance due to:
  - Substitute placement foster care (up to age 21)
  - Subsidized adoptive placements (up to age 21)
  - Supplemental Security Income (SSI, up to age 21)
  - The Katie Beckett provision (up to age 18)

In the past, these populations have received health care services through either the RIte Care program or traditional fee-for-service Medicaid. Over the past two years, DHS has initiated strategies designed to stabilize the rapidly growing RIte Care program, both by implementing RIte Share, Rhode Island's premium assistance program for employer sponsored health care coverage, and through the implementation of cost sharing for RIte Care and RIte Share enrollees. In addition, the Department has worked to contain the growth in expenditures for services and enhance the quality, access and coordination of care for children with special health care needs beginning to enroll them in RIte Care. In addition, the Department restructured the service delivery system through the CEDARR Initiative.

RIte Care

RIte Care is Rhode Island's Medicaid managed care program for low-income and uninsured children, parents, and pregnant women. RIte Care was implemented in 1994 under a Section 1115(a) waiver. The waiver allowed Rhode Island to create a comprehensive, coordinated health care delivery system through competitively procured contracts with licensed Health Maintenance Organizations (Health Plans). RIte Care implementation changed the nature of the delivery system for Medicaid enrollees by enrolling members in a health plan, providing every member with his or her own primary physician and implementing standards for provider accessibility and responsiveness. A core goal was to increase access to appropriate, timely primary care, including preventive care and "sick visits", thus decreasing the reliance on less appropriate emergency department visits and reducing avoidable hospitalizations.

RIte Care has increased enrollee access to health care and improved health outcomes, while containing the growth of costs. Not all managed care is alike: RIte Care has several key design features specified in the Health Plan contracts that are quite different from health plans' commercial contracts. These design features, along with oversight and monitoring by the State, are key ingredients in RIte Care's success. Evaluations of RIte Care have shown very significant improvements in participants' access to timely primary care as well as specialty care. Choice has been expanded by providing access to a much wider network of primary care and specialist providers than has been available in fee-for-service Medicaid. Overall, 97 percent of enrollees indicate that they are very satisfied or satisfied with RIte Care - a percentage that has remained relatively consistent for the past five years.

RIte Care has had a significant impact on the uninsured in Rhode Island. At its inception, 11.5 percent of the total population and 9 percent of children were uninsured. In 2000, the uninsured population in Rhode Island had dropped to 6.2 percent and 2.4 percent, respectively, the lowest in the nation.

As of June 30, 2002, 117,024 individuals were enrolled in RIte Care, including 1,983 children in state foster care. Health Plan enrollment as of that date was:

- NHPRI: 67,410
- United: 41,900
- Blue Chip: 7,714

RIte Care Enrollment Growth

From 1995 through 1998, RIte Care's enrollment remained fairly stable, ranging from 70,000 to 75,000. In 1999, enrollment growth expanded significantly, growing to 104,000 by June 2000. This increase was due to four concurrent events:

- In October 1998, RIte Care initiated a streamlined eligibility process, allowing potential eligibles to apply by mail.
- In November 1998, eligibility was expanded to parents of RIte Care enrolled children with family income up to 185 percent FPL.
- Between January 1999 and June 2000 an aggressive outreach campaign identified and enrolled many RIte Care eligible families.

- In late 1999, Rhode Island's commercial insurance market began to deteriorate, as Harvard Pilgrim Health Care left the state and premiums offered by the remaining commercial carriers increased dramatically. These cost increases had an adverse effect on many small firms and low-wage workers.

In response to this growth and the instability in the small group health insurance market, the Governor and the Legislature moved quickly to enact a legislative package under the title Health Reform Rhode Island 2000. The law had three components:

- **Health Reform, RI 2000.** This Act established the RIte Share program, a combined Medicaid/SCHIP premium assistance program intended to assist low-income families with the cost of employer-sponsored coverage. The Act also authorized the Department to implement cost-sharing for Medicaid and SCHIP expansion populations.
- **Small Employer Market Reform.** To bring Rhode Island into compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, the reform effort by compressing rate bands in order to stabilize premiums in the small group market, and by requiring that health insurers issue a basic health plan. The Department of Business Regulation has authority for this component of the legislation.
- **Financial Reserve Requirements.** This component made Rhode Island's financial reserve requirements for health insurers consistent with the National Association of Insurance Commissioners model legislation. The authority for this component rests with the Department of Business Regulation.

RIte Share

In February 2001, DHS began marketing RIte Share to employers and, in April 2001, began transitioning RIte Care enrollees into RIte Share. RIte Share has been implemented with several features that were designed to streamline administrative complexities encountered by other states that implemented premium assistance programs. These unique features include:

a. **Two options for premium payment:** Initially, RIte Share paid an eligible employee's premium share directly to his or her employer. This allowed the employer to pay the insurer the entire premium, with no employee payroll deduction needed. This strategy met with limited success (275 RIte Share members as of January 15, 2002). In late 2001, DHS began to transition all RIte Care enrollees with access to employer sponsored coverage into RIte Share on a mandatory basis, and to reimburse the employee directly for the family's share of coverage. Regulations to allow this were finalized on January 15, 2002. Since then RIte Share enrollment has steadily increased. As of June 2002, over 2,000 parents and children were transitioned from RIte Care into RIte Share.

b. **Broad standards for qualifying health plans:** Rhode Island has set broad qualifying parameters in order to approve most health plans offered in Rhode Island. As a result of working closely with the three Rhode Island-based insurers, Rhode Island has pre-approved most plans offered by Rhode Island insurers to qualify for RIte Share. Rhode Island will meet minimum Medicaid and SCHIP requirements by utilizing fee-for-service Medicaid to cover co-payments and Medicaid services not covered under the employer's commercial coverage. To avoid an administrative burden for insurers and providers, this was designed to fit with their existing coordination of benefits billing and payment systems.

c. **Employer-based cost-effectiveness test:** Rhode Island uses a cost-effectiveness test that is applied employer by employer rather than for each family. This addresses two issues. The first is administrative simplicity. A participating employer's plan is qualified once a year on the basis of benefits and cost-effectiveness. Any RIte Care enrollee or applicant with access to coverage from that employer is immediately enrolled in RIte Share without requiring an additional cost-effectiveness or benefit test. Second, an employer-by-employer test will not adversely impact the commercial market as an individual family test may. With the family-by-family test, most small (one and two person) families stay in full public coverage (RIte Care) while larger families stay in commercial coverage with a state subsidy of the employee's premium (RIte Share). Over time, this will increase family coverage premium rates for that employer, and will make it less likely that employers will participate. The employer-based test avoids this problem.

d. **Mandatory enrollment under both Medicaid and SCHIP:** For any enrollee or applicant with access to a qualifying employer sponsored plan, enrollment in RIte Share is mandatory as a condition of eligibility under both Medicaid and SCHIP. This will assure maximum enrollment in RIte Share, thus maximizing use of Rhode Island's limited resources.

DHS has learned much from this intensive effort. DHS has developed the systems and skills to support a steady transition from RIte Care to RIte Share, albeit at a slower pace than originally projected. A by-product of the slower pace is that the impact on the business community has not been drastic or sudden as originally feared.

The knowledge gained through the RIte Share implementation process has provided a firmer basis for projecting for RIte Share enrollment and savings as of June 2002:

- **ENROLLMENT:** As of June 2002, 2,018 individuals were enrolled in RIte Share. At the current level of effort and given the limitations of needed information received from members and employees about available coverage, DHS can transition about 300 RIte Care members to RIte Share each month.
- **SAVINGS:** In RIte Care, DHS pays health plans $450 per month for an average RIte Care family. RIte Share's average monthly contribution to a family's employer-sponsored coverage is $338 (approximately half of the monthly cost of family coverage in the Rhode Island commercial market). The savings to the state per family in RIte Share is on average $112 per month, or $1,344 per year. The state savings are $650 per year, and the remainder is the federal savings.

Total savings from RIte Share were $160,000 ($75,000 state revenue) in FY 2002 and are estimated to reach $1.7 million ($825,000 state) in FY 2003.

Cost-Sharing

A second component of the Health Reform Rhode Island 2000 legislative package mandated cost-sharing for RIte Care and RIte Share families with family income above 150 percent of the FPL ($22,530 for a family of three). Between January 1, 2002 and July 31, 2002, targeted families were required to pay monthly per-family premiums of $43-$58 per month (up to three percent of family income). As of August 1, 2002, state law mandated that cost-sharing be raised to five percent of FPL ($61 to $92 per month). As of April 1, 2002, there was a 90 percent successful payment rate, which is much higher than other states have experienced.

Monthly premiums are collected in two ways:

- For RIte Care, DHS sends a bill and the family pays DHS directly by mailing a check.
- For RIte Share, DHS deducts the monthly premium from the amount it reimburses the member for the employee's share of employer coverage.

About 10 percent of all RIte Care/RIte Share enrollees (approximately 5,200 families) were subject to cost sharing beginning January 1, 2002. Before cost sharing was implemented, in November 2001 families received two letters and an official notice about the change. First monthly bills were mailed in December requiring payment by January 1, 2002.

Any family who is two months in arrears is disenrolled from coverage and can not enroll for four months. Both DHS staff and RIte Care Health Plans attempted to contact all families who were two months behind in payments. Approximately 60 percent of these families were reached by telephone. Of families reached, approximately 20 percent reported that they intended to let their RIte Care coverage lapse either because they had other affordable coverage or they could not afford the monthly premium.

Approximately 30 percent intended to pay their bill prior to the due date. Approximately 40 percent of the families who were two months behind in payment could not be reached. Many of these families may have moved or had changes in their family living arrangements. This experience is consistent with that of other states.

On April 1, 2002, 549 of the 5,200 families subject to premium cost-sharing were discontinued from coverage for failure to pay two months of premium. Ninety percent of families subject to cost sharing paid their premiums, while only 10 percent received a sanction.

In total, $1.2 million ($600,000 state revenue) were collected from family cost sharing in FY 2002. An additional $2.4 million ($1.2 million state revenue) is expected to be collected in FY 2003.

Impact of RIte Share and Cost-Sharing on RIte Care

In FY 2002, combined RIte Care and RIte Share enrollment growth averaged 547 individuals per month. This reflects a continued reduction in the rate of growth when compared to previous years:

- In FY 2000, RIte Care enrollment growth averaged 1,452 per month. This was during the time of crisis in Rhode Island's health insurance market, discussed earlier in this paper.
- In FY 2001, RIte Care enrollment growth averaged 501 per month, (excluding foster children transitioned from FFS Medicaid to RIte Care).

The implementation of RIte Share and cost-sharing has achieved its intended purpose of stabilizing growth and expenditures of RIte Care.

Foster Care Initiative

In FY 2001, RIte Care began enrolling children in substitute placement foster care. Previously, RIte Care children who were placed in foster care were disenrolled from RIte Care. Any child already participating in foster care would be enrolled in fee-for-service Medicaid. Historically, 70 percent of foster care children had previously been RIte Care members. In preparation for the RIte Care enrollment of children in substitute care, the Department of Children, Youth and Families and DHS established governing principles for the partnership and invited Health Plans to participate. Currently, only NHPRI enrolls children in substitute care.

The partnership between DHS, DCYF and NHPRI facilitated several system changes. The behavioral health provider network available to children in substitute care was substantially strengthened by including all DCYF active and specialty behavioral health providers in the NHPRI behavioral health provider network. The DCYF and NHPRI have developed a data exchange capability that enables daily data exchanges between organizations. This exchange provides NHPRI with current placement information on these children and gives DCYF the name of each child's current primary care provider.

As of July 2002, 1,983 children in substitute care were enrolled in RIte Care.

Representatives of DHS, DCYF and NHPRI have achieved consensus in many key areas essential to meeting the medical and behavioral health needs of this vulnerable population, such as identifying access to care barriers.

CEDARR Initiative

The Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) Initiative is a family-centered, strength-based and data-driven system of evaluation, care planning, family information and support and timely access to health services for eligible children with special health care needs. It was developed based on the recommendations of the Leadership Roundtable for Children with Special Health Care Needs. The CEDARR Initiative is comprised of two major efforts: (1) CEDARR Family Centers, which began operating in FY 2001; and (2) CEDARR Direct Services (under development in FY 2002).

CEDARR Family Centers

The CEDARR Family Centers provide:

1. Basic services and supports:
   - Information
   - Special needs library and info-line
   - Resource identification
   - System mapping and navigation
   - Peer family guidance
   - Initial family assessment
2. Specialized services:
   - Clinical capacity in a designated specialty area
   - Crisis intervention and management 24hrs/day
   - Comprehensive evaluation, diagnosis and assessment
   - Family care planning
   - Re-evaluation of care plans
   - Quality assurance/data collection/outcome measures

The CEDARR Family Center assigns a Family Service Coordinator and clinician to each child and his or her family. The CEDARR Family Center staff provide information, identify needed services, make referrals and assure the coordination of care among the child's physician, the child's school and other service providers. Services are available statewide and there are no out-of-pocket expenses for Medicaid eligible children.

In FY 02, the CEDARR Family Centers assisted 449 children and their families. Of these, 426 were new clients who first contacted a CEDARR Family Center in FY 02. Of the children who were new to a CEDARR Family Center in FY 02, two-thirds were male, ten percent spoke a primary language other than English, and over half were under age 8 at first contact. While 59 percent of new clients are Medicaid fee-for-service enrollees, an additional 32 percent were RIte Care members. The remaining 9 percent receive coverage through another State agency program or through private insurance.

Currently four CEDARR Family Centers operate around the state. *About Families* opened in FY 01, and *Family Solutions* and *Families First* opened in July 2001 and July 2002, respectively. A fourth center, Easter Seals, opened in October, 2002.

CEDARR Direct Services

When fully implemented, CEDARR Direct Services will improve access to the continuum of care for children with special health care needs. In FY 2001, The CEDARR Policy Advisory Committee and the Leadership Roundtable for Children with Special Health Care Needs met to develop service definitions, identify the populations in greatest need of the service and desired outcomes for those individuals. The workgroups identified issues and problems with the current system, focusing on the users, providers, scope and intensity of services, and pricing. The groups proposed enhancements regarding: quality of care standards; staff qualifications; quality assurance; access to services; and potential provider networks.

Standards have been issued and providers certified for Home-Based Therapeutic Services (HBTS). CEDARR Family Centers can refer a family to HBTS. Two other services are in development. Standards for Therapeutic Services in Child and Youth Care were released for public comment in fiscal year 2003. Pediatric Home Care standards are currently in development.

Also in FY 2002, CMS awarded DHS and its partners a Community-Integrated Personal Assistance Services and Supports (PASS) grant. This grant supports the design and implementation of a consumer directed program for children with special health care needs living in the community. The Center for Child and Family Health is developing definitions and standards for this new service in order to expand the continuum of care for children with special health care needs. Once implemented, the program will maximize control and choice for these children and their families as they seek to meet their children's personal needs.

The CEDARR Quality Panel, which is composed of members of the interdepartmental CEDARR team and clinical staff from CEDARR Family Centers, convened in November 2001. The group meets monthly to identify the issues, strengths and challenges of CEDARR Family Centers, and to identify best practices that will assure family satisfaction and positive outcomes for children.

The Center for Child and Family Health is also working with DCYF to develop new standards and definitions for Children's Intensive Services (CIS).

Transitioning Children with Special Health Care Needs into RIte Care

In FY02, approximately 7,800 children with special health care needs received health care through Rhode Island Medicaid on a fee-for-service basis. Almost two-thirds of these children qualified for Medicaid due to Supplemental Security Income (SSI) eligibility, which is based on the family's income and the child's health status.[5] An additional twelve percent of the these Medicaid-eligible children with special health care needs qualified under the "Katie Beckett" provision, where eligibility is based upon the child's (not the parents') income and resources and the determination that the child needs an institutional level of care and the cost of caring for the child at home is less than the cost of care in an institution. The remainder of the non-RIte Care enrolled children with special health care needs were Medicaid-eligible by virtue of their qualification under Rhode Island's adoption subsidy program.

A Governor's budget initiative for FY03 directed DHS to design a service delivery strategy that will allow Medicaid eligible children with special health care needs to be enrolled in RIte Care and have their routine and specialized health care needs met through the participating health plans. The DHS began implementing this initiative in FY02, pursuing input from a broad range of stakeholders and seeking approval of the project from the Federal Centers for Medicare and Medicaid Services (CMS). To gain approval, DHS amended its existing RIte Care Section 1115 Research and Demonstration waiver.

The State believes children with special health care needs can benefit from improved access to care and service coordination afforded through RIte Care, by utilizing a service delivery strategy focused on the children's unique needs, the strengths of the family, and coordination of services. Enrollment in RIte Care will expand provider availability and access to quality, timely provision of services. Slowing the rate of increases in costs is an anticipated by-product of improved care.

The eligibility policies for and benefits available to these children with special health care needs will not change. The State plans to enroll into RIte Care those children who have no other health

insurance coverage, or about two-thirds of the overall group. Children who have other insurance will continue in Medicaid fee-for-service with Medicaid coverage to "wrap around" or supplement the commercial benefit package.

School-based health services

Approximately 50 percent of the children with disabilities who receive special education services in Rhode Island are Medicaid eligible. All Rhode Island school districts are participating Medicaid providers. The DHS works with Local Education Agencies (LEAs) and the Department of Education to maximize local schools' ability to receive Medicaid funding for needed medical and dental care provided to Medicaid eligible students. In FY 2001, an administrative claiming program was implemented. This resulted in $22.2 million in LEA revenue in FY 2002.

Lead Centers

In 1998, DHS began developing and funding lead poisoning prevention, case management and treatment programs, targeting Medicaid eligible children. Due to Rhode Island's aging housing stock, many children have been exposed to environmental conditions resulting in elevated lead blood levels, with an adverse impact on growth and development. To ameliorate lead poisoning and prevent new exposures, DHS developed a coordinated spectrum of services designed to be family and home-oriented and managed on a case-by-case basis.

5. Targeted enrollees are individuals under age 21 who are eligible for Medicaid due to SSI or a Subsidized Adoptive Agreement, and those under age 18 who are eligible through the Katie Beckett provision.

The Department monitors and oversees the Certified Lead Centers' compliance with certification standards originally developed in 1998. The DHS funds the H.E.L.P Lead Safe Center in Providence, which assists families through intensive case management, coordination of housing inspections, relocation assistance, family education, training on cleaning techniques, referrals to medical, legal, nutritional, early intervention, special education, intensive environmental cleaning and other services. The Department reimburses for window replacement costs in the homes of RIte Care enrolled children with significant lead poisoning.

The Lead Center certification standards were revised in fiscal year 2002. In June 2002, the Department received four applications from programs wishing to become certified as Lead Centers. In FY 2002, 271 families accessed services for 585 children to which they were referred due to elevated lead levels.

Drug Court

The Rhode Island Family Court, Attorney General, Public Defender, DCYF, MHRH, DOH and DHS collaborated to plan and develop the Rhode Island Family and Juvenile Drug Court. The Juvenile Drug Court grew out of a recognized need for a therapeutic approach to nonviolent juveniles whose involvement in Family Court is attributable to their dependency upon alcohol and other drugs. In addition, there is evidence that a specialized court can enhance public safety by breaking the cycle of recidivism.

Juvenile Drug Court was launched in December 1999. In FY 2002, 50 participants were admitted to the program. Forty-four graduated during the year. Through a series of amended administrative orders, the program was expanded from Providence and Bristol Counties to cover juveniles living anywhere in Rhode Island.

RWJF State Coverage Initiative Grant

In FY2002, Rhode Island was one of only four states to receive a three-year demonstration grant from the Robert Wood Johnson Foundation's State Coverage Initiative (SCI) Program. The SCI demonstration grants are targeted to states that are ready to achieve a sizable coverage objective, such as significantly reducing the number of working uninsured or designing a novel coverage model or partnership. Rhode Island's project is designed to reduce the level of uninsured in the state by fully implementing RIte Share. Major grant activities include: (1) conducting a formative evaluation of RIte Share operations to ensure that the program is designed to maximize enrollment and budgeted cost-savings, and using this evaluation to create a how-to manual for other states starting premium assistance programs; (2) developing and implementing a management information system for RIte Share that facilitates monitoring and continuous improvement in the areas of enrollment, cost-effectiveness and access to appropriate, effective health care services; (3) conducting, in partnership with the Department of Health, a statewide survey of patterns in employer health insurance to assess trends from a similar survey conducted in 1999 and to elicit feedback from employers concerning RIte Share; (4) conducting a study of the impact of "churning" (frequent change of coverage status) on access to care for Rhode Island's low-income working population; and (5) in partnership with the Brown Medical School, establishing a research fellowship that will facilitate the application of Brown's significant health services research capacity into Rhode Island Medicaid's design and evaluation.

Personal Assistance Services and Supports (PASS)

In 2002, the Centers for Medicare and Medicaid Services awarded Rhode Island a grant to implement a Personal Assistance Services and Supports (PASS) program. The Department of Human Services is using the grant to design and implement a consumer-directed PASS program that will maximize control and choice for children with special health care needs and their families, potentially substitute for other high demand therapeutic services, expand the pool of current service providers, and improve the continuum of services for children. ▼

CHILDREN AND FAMILIES IN MANAGED CARE

Population Characteristics

In FY 2002, children under age 18 accounted for 65 percent of the 117,460 people in the average monthly RIte Care caseload. Approximately three-quarters of the adults were female. Ninety-six percent of RIte Care members had household incomes below 185 percent of the federal poverty level (FPL), or below $27,787 for a family of three. Twenty-two percent of the population spoke a language other than English as their primary language spoken at home. The second most common language, Spanish, was spoken by 18 percent of RIte Care members.

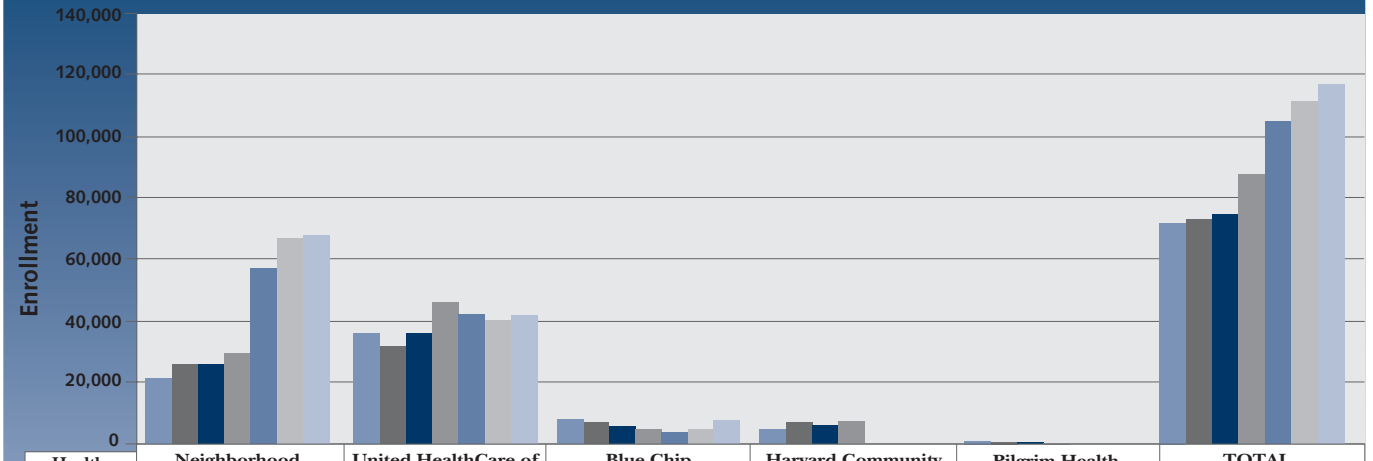
In 1997, RIte Care enrollment was distributed across three to five health plans (see **Exhibit 16**). When Harvard Community Health Plan and Pilgrim Health Plan left Rhode Island early in FY 2000, enrollees were transferred into the only RIte Care health plan still open to new enrollees, Neighborhood Health Plan of Rhode Island (NHPRI). Both United Healthcare of New England and Blue CHiP began accepting new Medicaid enrollees in FY 2001. An open enrollment for all three plans was conducted in April and May. At the end of the fiscal year, 58 percent of all RIte Care members were enrolled through NHPRI. United Healthcare and Blue CHiP had 36 percent and 6 percent of RIte Care members, respectively.

Services and Expenditures

In FY 2002, total Medicaid expenditures for the population were $262 million an increase of 14 per cent over the previous year.

16

Exhibit 16
RIte Care Enrollment* by Health Plan
FY 1996 to 2002



Health Plan	Neighborhood Health Plan	United HealthCare of New England	Blue Chip	Harvard Community Health Plan	Pilgrim Health Plan	TOTAL
1996	21,531	36,069	8,323	4,730	1,093	71,746
1997	26,438	31,740	7,438	6,616	901	73,133
1998	26,318	35,926	5,919	6,250	674	75,087
1999	29,130	46,250	4,965	7,344	28	87,717
2000	57,315	42,747	4,381	--	--	104,443
2001	67,057	39,964	4,603	--	--	111,624
2002	67,410	41,900	7,714			117,024

*Unduplicated count by health plan

Exhibit 17 displays FY 2002 average per client per month (PCPM) expenditures by service for children and families in managed care. The total PCPM includes services funded by DHS, DCYF and the LEAs for capitation payments to health plans, additional funds paid to health plans for services provided beyond the capitation package (such as unlimited mental health services), and funds paid directly to providers for services not provided by the health plans (including dental and transportation). Between FY 2001 and FY 2002, the total PCPM grew 10 percent to $184. The three largest expenditure categories, accounting for over 80 percent of all expenditures, were as follows:

- $72 PCPM for physician and other professional services (including outpatient hospital services)
- $57 PCPM for hospital services (including inpatient and emergency department services)
- $25 PCPM for pharmacy

Children with Special Health Care Needs

Population Characteristics

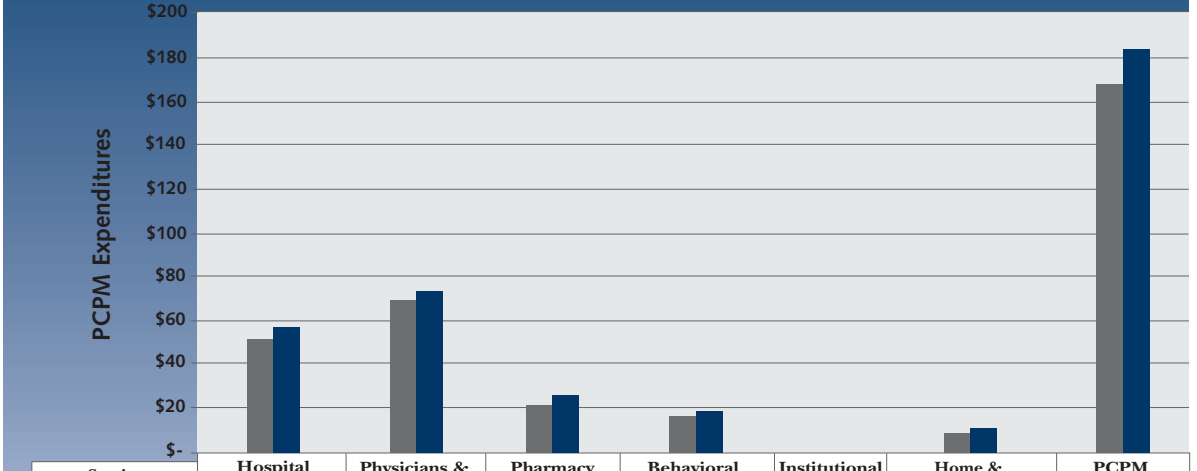
An average of 11,296 children with special health care needs were enrolled in Medicaid each month during FY 2002, a decrease of nine percent from the previous year. Children in this subgroup are eligible for Medicaid because they are enrolled in SSI, under the Katie Beckett provision, in adoption subsidy or in substitute care. Eligibility for SSI is based on family income and the child's health.

Children with special health needs who do not meet SSI eligibility requirements may be found Medicaid eligible if they meet the requirements of the Katie Beckett provision. "Katie Beckett" eligibility is based on: (1) the child's income and resources only (not the parents'); and (2) a calculation that the cost of caring for the child at home is less than the cost of care in an institution.

A third group of children with special health care needs is made up of individuals under age 21 who have been adopted through

17

Exhibit 17
Children & Families in Managed Care
PCPM Program Expenditures by Service Provider
FY 2001 and FY 2002

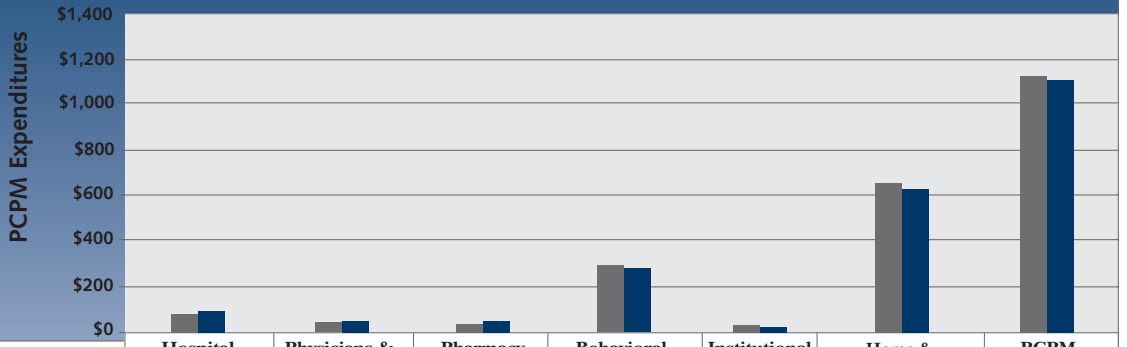


Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services*	PCPM TOTAL
2001	$53	$69	$21	$16	--	$8	$167
2002	$57	$72	$25	$18	--	$11	$184

*excludes residential services for children in foster care who are enrolled in RIte Care

18

Exhibit 18
Children with Special Health Care Needs
PCPM Program Expenditures by Service Provider
FY 2001 and 2002



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM TOTAL
2001	$87	$46	$40	$292	$28	$661	**$1,153**
2002	$91	$50	$50	$289	$23	$626	**$1,139**

subsidized adoptive arrangements. The agreement between the state and the adoptive parents includes a provision indicating that the child will remain Medicaid eligible until he or she turns 21.

Services & Expenditures

Total Medicaid program expenditures for this population were $154 million, an increase of five percent from FY 2001 expenditures. The total per capita per month (PCPM) spending was $1,066. Two service provider categories represented over 80 percent of all expenditures, i.e.:

- $626 PCPM for home and community-based services (including EPSDT services, intensive home-based therapy, private duty nursing, and certified nursing assistant services)
- $ 289 PCPM for behavioral health services.

Tracking Access, Quality and Outcomes

Children and Families in Managed Care

In order to measure RIte Care's impact on health care access, quality and outcomes, Rhode Island Medicaid established the Research and Evaluation Project within the Division for Health Care Quality, Financing and Purchasing. The Research and Evaluation Project evaluates what programs work and how change occurs.

Throughout most of the 1990s, research and evaluation efforts focused on the children and families enrolled in RIte Care. As the RIte Care evaluation began to show that the program had a positive impact on health status and outcomes for the target population, Medicaid began expanding the Research and Evaluation Project to other population groups.

For the past eight years, Medicaid has been measuring RIte Care's access, quality and outcome effects. This has allowed the program to track progress in the health and health care

of the population over time. RIte Care enrollees have experienced significant improvements in their access to health care and health status, including primary, pediatric, and prenatal care, increased inter-birth intervals, decreased maternal smoking, positive trends in low-birth weight among RIte Care newborns, and increased childhood immunization and lead screening rates. RIte Care contributed to the significant reduction in Rhode Island's rate of uninsurance to 6.2 percent, the lowest in the nation in 2000 and has contributed to the following:

- *Decrease in the uninsured population.* Rhode Island's coverage expansions have decreased the uninsurance rate of children. The percentage of uninsured children in Rhode Island dropped from 12.5 percent in 1995 to 2.4 percent in 2000.
- *Increased inter-birth interval.* RIte Care has positively impacted maternal health. An increasing number of women on Medicaid wait at least 18 months between births, from 60 percent before RIte Care implementation (1993-94) to 78 percent in 2000. Women receiving Medicaid and those with commercial health insurance now have inter-birth intervals of similar length.
- *Reduction in smoking during pregnancy.* The percentage of pregnant women on Medicaid who smoked during pregnancy decreased significantly, from 32 percent in 1993 to 24 percent in 2000.
- *Improved access to prenatal care.* In 2000, 84 percent of women on Medicaid began prenatal care in the first trimester, up from 77 percent in 1993.
- *Increased adequacy of prenatal care.* The number of women on Medicaid receiving adequate prenatal care increased significantly, from 56 percent in 1993 to 73 percent in 2000. ▼

Children With Special Health Care Needs

Recent studies on children with special health care needs indicated room for improvement in the care of these children. Central are the opportunities to enhance quality, access and coordination of care for children with special health care needs. The State plans to build on RIte Care's successes by enrolling children with special health care needs into the program's participating health plans in the first part of calendar year 2003.

Baseline Health Indicators

In calendar year 2000[6], 12,062 children were enrolled in the four subgroups that encompass children with Special Health Care needs: children eligible due to SSI (45%); children in subsidized adoptions (38%); children eligible due to the Katie Beckett provision (8%) and children in substitute care placements (8%). The DHS reviewed utilization data for these children, finding:

- The annual hospitalization rate per 1,000 individuals was 173. Children in substitute care had the highest rate of hospitalization, at 262 per 1,000 children.
- Over 7 percent of all children with special health care needs were hospitalized. Of those hospitalized, over 21% had a length of stay greater that 30 days. Thirty-two percent of children in substitute care were hospitalized for longer than 30 days.
- Mental disorders were the leading cause of hospitalization for all four groups. Eighty-seven percent of hospitalizations for children in substitute care were for mental disorders.
- Fifty-seven percent of the children with hospitalizations were admitted more than once.
- The emergency department visit rate for children with special health care needs was 443 per 1,000. Children enrolled due to SSI eligibility have the highest rate of emergency department visits, at 599 per 1,000. ▼

6. Calendar year 2000 is the most recent year for which utilization information is available.

Web Site Links

Look on the DHS web site: www.dhs.state.ri.us for the following links to find more information about topics discussed in this report.

- What is Medicaid?
  - History of Medicaid
- How is RI Medicaid Administered?
  - Partnerships for Serving the RI Medicaid Population
- Who is Eligible?
- What Services are covered?
- How is Medicaid Financed?
- How is Rhode Island's Medicaid Budget Determined?
  - Caseload Projections & Budget Forecasts
- What is a Waiver?
- Research & Evaluation Project
  - 2001 description
  - Evaluation Studies Work Group
  - Publications

References

- Bullen, Bruce, NASMD Chair and Commissioner, Massachusetts Division, of Medical Assistance, What is a Prudent Purchaser?, keynote speech presented to the NASMD/HCFA Medicaid Managed Care Meeting on February 26, 1998.
- Allen, Susan et al , The Faces of Medicaid, Center for Health Care Strategies, Inc ., Robert Wood Johnson Foundation, October 2000.
- Center for Health Care Strategies, Inc., Effect of Medicaid Maximization and Managed Care on Cooperation, Collaboration and Communication within State Governments, July 1999.
- Evaluation Studies Workgroup. Design of a Health Indicator System: A "How-To" Manual for State Medicaid Programs, 2000.
- Fossett, James, et al "Prudent purchaser discussion: Managing Medicaid Managed Care: Are States Becoming Prudent Purchasers?," Health Affairs, Vol 19, #4, July/Aug 2000.
- Griffin, Jane, Profiles and Trends of the Uninsured in Rhode Island, April 2002.
- Griffin, Jane, The Impact of RIte Care on Adequacy of Prenatal Care and the Health of Newborn., 2000 Update, April 2002.
- Griffin, Jane, A 1999/2000 Comparison of Hospital and Emergency Department Health Indicators for SSI and Foster Children and Adolescents, June 2002.
- Oklahoma Health Care Authority, "Annual Report SFY 2000."
- Payne, Christine, Healthcare Needs of Adults with Physical Disabilities Living in the Community. Results of Four Focus Groups with Rhode Islanders on Fee-For-Service Medicaid, 2001.
- Payne, Christine, Needs Assessment Survey of RI Working-Age Adults with Physical Disabilities and Chronic Health Conditions on Fee-for-Service Medicaid, February 2002.
- Payne, Christine, Hospital and Emergency Department Utilization for Working-Age Rhode Islanders on Fee-For-Service Medicaid, A Health Service Indicator Trends Report: 1998-2000. May 2002.

Acknowledgements

Project Team

John Young, Senior Editor
Associate Director
Division of Health Care, Quality
Purchasing and Finance

Melinda Thomas
Consultant and
Associate Director
Office of Primary Care
Brown Medical School

Nora Leibowitz
Program Analyst
Division of Health Care, Quality
Purchasing and Finance

Editorial Panel

Tricia Leddy
Administrator
Center for Child & Family Health

Frank Spinelli
Administrator
Center for Adult Health

Murray Blitzer
Administrator
Management Services

Production

Diana Creed
Horizon Communications

Printing

Pucino Print Consultants

Contributors

John Andrews
Diana Beaton
Murray Brown
Nolan Byrne-Simpson
Ron Chopoorian
Ann Chiodini
Deb Florio
Jane Griffin
Lynne Harrington
Rick Jacobsen
Diane Kayala
Judi Lena
Ellen Mauro
Bill McQuade
Christine Payne
Bill White

Rhode Island Department of Human Services
600 New London Avenue
Cranston, RI 02920
401-462-3575
Jane A. Hayward, *Director*
Donald L. Carcieri, *Governor*
www.dhs.state.ri.us

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
600 New London Avenue
Cranston, RI 02920
401-462-3575
www.dhs.state.ri.us